



Best Practices in Treating Depression in People with Dementia

Vicki Clithero, RN, DNP

Clinical Nurse Educator

Objectives

- Identify the consequences of depression among those with dementia.
- Discuss clinical monitoring of those with dementia and symptoms of depression.
- Review the side effect profiles of commonly prescribed anti-depressant medications.
- Identify best non-drug practices in treating depression among those with dementia.
- Collaborate in planning an evidence-based strategy to reduce depression for a resident with dementia.

Depression Among AL Residents

- Depression is one of several ***neuropsychiatric symptoms of dementia***
- Most frequently reported
 - Apathy
 - **Depression**
 - Agitation
 - Delusions and hallucinations
 - Sleep impairment
- 16% of those with dementia have major depressive disorder
- 32% of those with dementia have symptoms of depression without formal diagnosis
- Depression is the most common mental illness among AL residents

Diagnosis of Depression

- Typically diagnosed by DSM-V diagnostic criteria
 - Older adults under-report
 - Cognitively impaired under-report
- National Institute of Mental Health
 - 3 or more present in same 2 - week period, and
 - Change in previous functioning, and
 - Depressed mood or decreased positive affect or pleasure
- Clinical picture can overlap with dementia



NIMH Diagnostic Criteria

Three or more must be present in same 2-week period	*At least one must be present
Clinically significant depressed mood*	Additional criteria:
Decreased positive affect or pleasure*	1. All criteria are met for Alzheimer's disease (DSM-V)
Social isolation or withdrawal	2. Symptoms cause clinically significant distress or disruption in functioning.
Psychomotor changes	3. Symptoms do not occur only in the presence of delirium
Irritability	4. Symptoms are not due to physiologic effects of any substance
Fatigue or loss of energy	5. Symptoms are not better accounted for by other conditions such as:
Feelings of worthlessness, hopelessness, or guilt	Major depressive disorder Bipolar disorder Bereavement Schizophrenia Schizoaffective disorder Psychosis of AD Anxiety disorders Substance-related disorders
Recurrent thoughts of suicide or death	

Assessment and Monitoring

- Cornell Scale for Depression in Dementia
 - Caregiver scores symptoms
- Geriatric Depression Scale
 - Self-report
 - Short form available
 - Useful for those with mild or moderate cognitive impairment
- Mini-Mental Status Exam (MMSE)

Geriatric Depression Scale

Date: 2016-08-12

Patient Name: TEST, TEST

	Yes	No	
1. Are you basically satisfied with your life?	0	1	<input type="checkbox"/>
2. Have you dropped many of your activities and interests?	1	0	<input type="checkbox"/>
3. Do you feel that your life is empty?	1	0	<input type="checkbox"/>
4. Do you often get bored?	1	0	<input type="checkbox"/>
5. Are you are you in good spirits most of the time?	0	1	<input type="checkbox"/>
6. Are you afraid something bad is going to happen to you?	1	0	<input type="checkbox"/>
7. Do you feel happy most of the time?	0	1	<input type="checkbox"/>
8. Do you often feel helpless?	1	0	<input type="checkbox"/>
9. Do you prefer to stay at home, rather than going out and doing new things?	1	0	<input type="checkbox"/>
10. Do you feel you have more problems with memory than most?	1	0	<input type="checkbox"/>
11. Do you think it is wonderful to be alive?	0	1	<input type="checkbox"/>
12. Do you feel pretty worthless the way you are now?	1	0	<input type="checkbox"/>
13. Do you feel full of energy?	0	1	<input type="checkbox"/>
14. Do you feel your situation is hopeless?	1	0	<input type="checkbox"/>
15. Do you think that most people are better off than you are?	1	0	<input type="checkbox"/>
Total (over 5 indicates depression)			<input type="checkbox"/>

Cornell Scale for Depression in Dementia

- 19 items on scale
- Useful in those with moderate to severe dementia
- Can be used to track effectiveness of interventions

Name: _____ Age: _____ Sex: _____ Date: _____

Cornell Scale for Depression in Dementia

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

SCORING SYSTEM

a = Unable to evaluate 0 = Absent 1 = Mild to Intermittent 2 = Severe

Score greater than 12 = Probable Depression

A. MOOD-RELATED SIGNS	a	0	1	2
1. Anxiety; anxious expression, rumination, worrying				
2. Sadness; sad expression, sad voice, tearfulness				
3. Lack of reaction to pleasant events				
4. Irritability; annoyed, short tempered				
B. BEHAVIORAL DISTURBANCE	a	0	1	2
5. Agitation; restlessness, hand wringing, hair pulling				
6. Retardation; slow movements, slow speech, slow reactions				
7. Multiple physical complaints (score 0 if gastrointestinal symptoms only)				
8. Loss of interest; less involved in usual activities (score 0 only if change occurred acutely, i.e., in less than one month)				
C. PHYSICAL SIGNS	a	0	1	2
9. Appetite loss; eating less than usual				
10. Weight loss (score 2 if greater than 5 pounds in one month)				
11. Lack of energy; fatigues easily, unable to sustain activities				
D. CYCLIC FUNCTIONS				
12. Diurnal variation of mood; symptoms worse in the morning				
13. Difficulty falling asleep; later than usual for this individual				
14. Multiple awakenings during sleep				
15. Early morning awakening; earlier than usual for this individual				
E. IDEATIONAL DISTURBANCE				
16. Suicidal; feels life is not worth living				
17. Poor self-esteem; self-blame, self-depreciation, feelings of failure				
18. Pessimism; anticipation of the worst				
19. Mood congruent delusions; delusions of poverty, illness or loss				

Comparison of Dementia, Mild Cognitive Impairment and Depression

Dementia	Mild Cognitive Impairment (MCI)	Depression
<ul style="list-style-type: none">Between 2-10% of cases start before the age of 65 years.After 65 years the prevalence doubles every five years.	<ul style="list-style-type: none">Between 15-20% of those aged over 65 have MCIMCI often occurs alongside depressionMCI is a risk factor for development of dementia	<ul style="list-style-type: none">Depression is the most common mental health problem in later life40% of those in post-acute care have a depression diagnosis
Symptoms include <ul style="list-style-type: none">Short-term memory lossProgressive loss of functional abilities including speech, recognition, and sequenced action.	<ul style="list-style-type: none">There are many causes of MCI<ul style="list-style-type: none">Depression and anxietyPhysical illnessSide effects of medications	<ul style="list-style-type: none">Studies of depressed adults show poor functioning, comparable to or worse than that of those with chronic medical conditions
<ul style="list-style-type: none">On average, people live 4.5 years after a diagnosis of dementia	<ul style="list-style-type: none">People with MCI have 10-15% increased risk for developing dementia	<ul style="list-style-type: none">Percentage of older adults reporting feeling anxious or depressed is 14-22%

Depression *and* Dementia?

- Journal of Alzheimer's Disease in 2021
- Study of nearly 15,000 between ages 20 and 89
 - 13% of young adults had moderate to high depressive symptoms
 - 34% of older adults had depressive symptoms
 - Risk of developing dementia with aging
 - 73% higher among younger adults
 - 43% higher among older adults
- Depression worsens memory loss of dementia
- Depression can exacerbate extreme and aggressive behavior
- Cortisol may damage hippocampus



Consequences of Depression

- Cardiovascular study of 3608 participants, over 10 years, in 4 U.S. counties
- Evaluated neuropsychiatric symptoms in those with dementia and mild cognitive impairment (MCI)
- Depression found in
 - 20% of those with MCI
 - 32% of those with dementia
 - Increased activity impairment
 - More rapid cognitive decline
 - Worse quality of life
 - Earlier admission to long-term care (from AL or home)
 - Higher caregiver depression



Routine Medications: Dementia and Mood Disorders

- **Mood Stabilizers**

- Lithium
- Valproate
- Carbamazepine

- **Antidepressants**

- **SSRIs**

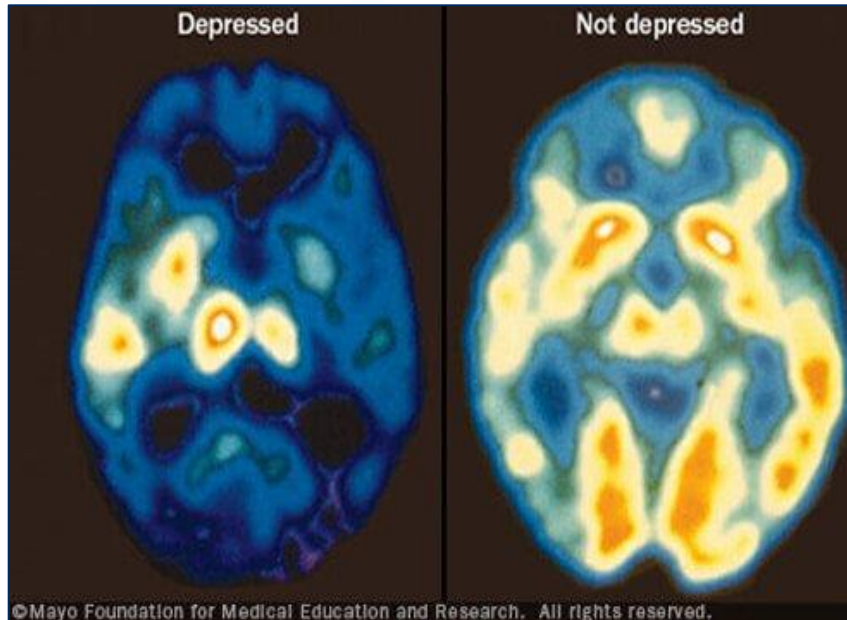
- Citalopram, escitalopram, sertraline

- **SNRIs**

- Venlafaxine
- Duloxetine

- **Tricyclics**

- Amitriptyline
- Trazodone



Antidepressants

- **Beer's Criteria**

- Tricyclic antidepressants
- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin-norepinephrine reuptake inhibitors (SNRIs)
 - **Avoid inpatients with history of falls or fractures**
 - Increased risk for orthostatic hypotension
 - Falls
 - Fractures
 - Increase risk of osteoporosis

- Amitriptyline has a strong anticholinergic effect and may worsen delirium
- All may exacerbate or cause SIADH and/or hyponatremia
 - Sodium levels must be closely monitored
- SSRIs and SNRIs can cause serotonin syndrome



How Effective are Antidepressants?

- 6 to 12 weeks for full effect
- Only 1 in 3 patients receive remission with first medication
- “Mild” side effects
 - Skin rashes
 - Worsening agitation
 - Somnolence
- Withdrawal can occur
 - With only 1 missed dose
 - Anxiety
 - Agitation
 - Insomnia
 - Flu-like symptoms

Table. Commonly used antidepressant medications for older adults.

Generic name	Trade name	Starting dose (mg/day)	Average dose (mg)	Maximum recommended dose (CPS) (mg)	Comments
SSRIs					
Citalopram	Celexa	10	20-40	40	
Escitalopram	Cipralex	5	10-20	20	
Sertraline	Zoloft	25	50-150	200	
Other agents					
Bupropion	Wellbutrin	100	100 b.i.d.	150 b.i.d.	May cause seizures
Mirtazapine	Remeron	15	30-45	45	
Moclobemide	Manerix	150	150-300 b.i.d.	300 mg b.i.d.	Do not combine with MAOB inhibitors or tricyclics
Venlafaxine	Effexor	37.5	75-225	375*	May increase blood pressure
Tricyclic antidepressants					
Desipramine	Norpramin	10-25	50-150	300	Anticholinergic; may cause cardiovascular side effects; monitor blood levels
Nortriptyline	Aventyl	10-25	40-100	200	Anticholinergic; may cause cardiovascular side effects; monitor blood levels

*For severe depression.

Adapted from guidelines of the Canadian Coalition for Seniors' Mental Health.¹

Cholinesterase Inhibitors

- Block normal breakdown of acetylcholine
 - Main neurotransmitter for
 - Muscle work
 - Attention
 - Learning
 - Memory
 - Motivation
 - Primarily used for treatment of dementia
 - Alzheimer's disease
 - Reduced levels of acetylcholine
 - Modest effect on dementia symptoms

Trade Name	Generic Name
Aricept, Aricept ODT	donepezil
Exelon	rivastigmine
Namzeric	donepezil/memantine
Razadyne, Razadyne ER, Remidyl	reminyl
Cognex	tacrine

Non –Drug Interventions

1. Cognitive stimulation
2. Cognitive stimulation + cholinesterase inhibitor
3. Massage and touch therapy
4. Environmental modification
5. Multidisciplinary care
6. Animal therapy
7. Occupational therapy
8. Exercise + social interaction + cognitive stimulation
9. Reminiscence therapy
10. Psychotherapy



Interventions that Outperform or Match Effect of Antidepressants

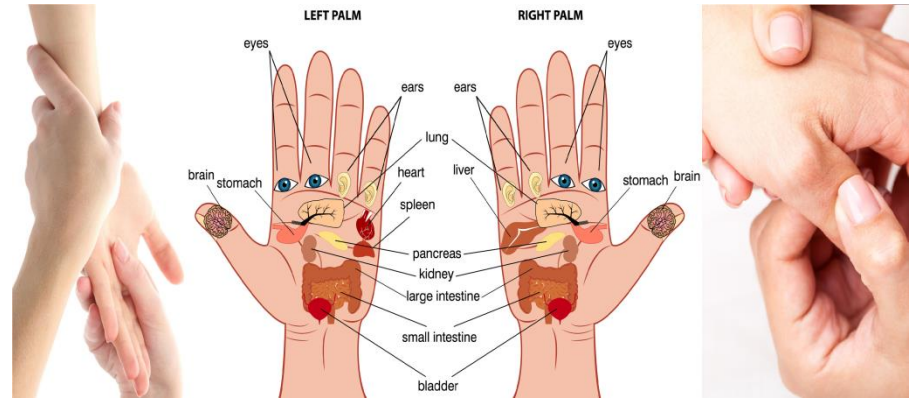
Outperform Antidepressants* Perform as Well as Antidepressants

- Massage and touch therapy
 - Cognitive stimulation + cholinesterase inhibitor
 - Cognitive stimulation + social interaction + exercise
- Multidisciplinary care
 - Occupational therapy
 - Reminiscence therapy
 - Cognitive stimulation
 - Animal therapy
 - Exercise
 - Psychotherapy + reminiscence therapy + environmental modification



Massage and Touch Therapy*

- Reduces neuropsychiatric symptoms
- Improves appetite
- Facilitates sleep
- Counteracts cognitive decline
- Lowers heart and respiratory rate
- Raises body temperature
- Communicates reassurance



Resources for Massage

- 5 minutes of hand massage is effective
- <https://www.youtube.com/watch?v=tAJ6JsITQo0>
- https://www.youtube.com/watch?v=u9pi-O_0TVM
- 10 minutes of foot and leg massage is calming
- https://www.youtube.com/watch?v=UhFb0Ea_wso



Cognitive Stimulation (CS)

- CS is the evidence-based non-drug therapy of choice for mild to moderate dementia
 - Effective in reducing neuropsychiatric symptoms, including depression
 - Play a role in delaying progression of Alzheimer's symptoms
 - Suitable for all types of dementia
- Alone, CS is as effective as antidepressants

St. Louis University Geriatric Education Center

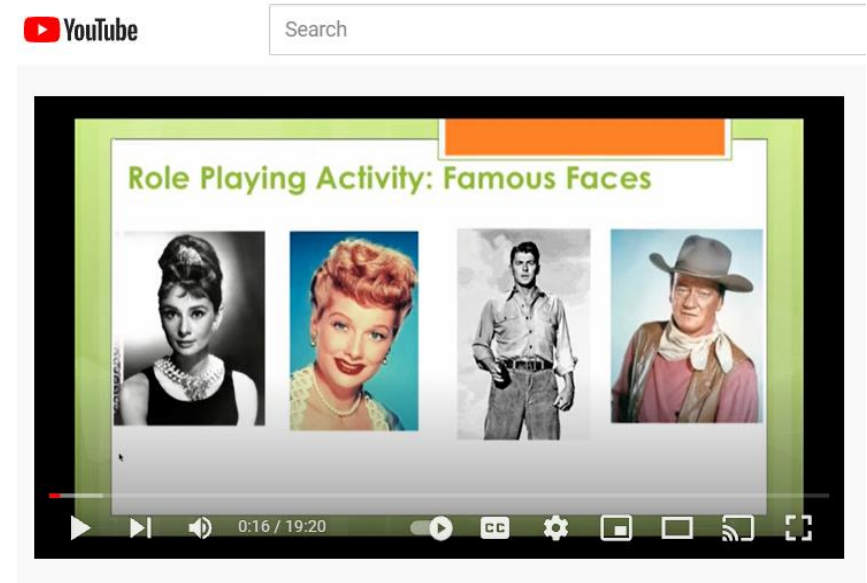


Search



Cognitive Stimulation Therapy Training

1. <https://www.youtube.com/watch?v=fIKqMknN0mU>
2. <https://www.youtube.com/watch?v=Tc9HnNXsnLQ>
3. <https://www.youtube.com/watch?v=6FKBoFBadhE>
4. https://www.youtube.com/watch?v=B0W_Xj8EtsY
5. <https://www.youtube.com/watch?v=ngRrDkWTLxE>



Outline and Structure for CS Therapy

1. Introduction

- Welcome each person
- State group name
- Sing theme song
- Soft ball toss
- Reference the day, weather, etc.
- Discuss interim events

2. Theme song

- Selected by group
- Short song or chorus

3. Current affairs

- Human interest stories
- Controversial topics are o.k.
- Print out articles for each

4. Main activity

- Select from manual
- Use as much sensory stimulation as possible

5. Follow-up activities

- For family or friends

6. Closure

- Next session
- Theme song

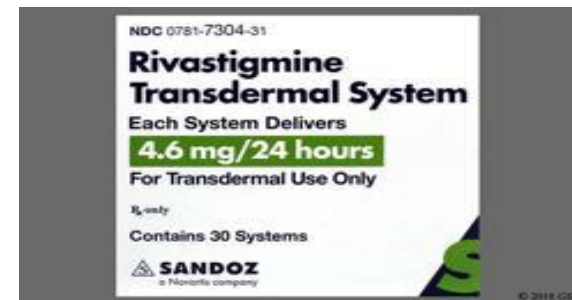
Exercise

- Planned balance, resistance, and aerobic activities
- Seattle Protocols – Regular, enjoyable exercise
 - Decreases physical disability
 - Delays disease progression
 - Improves mood
- Plan should include problem-solving strategies to overcome obstacles
- Interpersonal support helps



Cognitive Stimulation + Cholinesterase Inhibitor*

- Study compared people with just rivastigmine transdermal patch with those with patch who received cognitive stimulation
 - 24 weekly sessions, 90 minutes each
- Significant decrease in scores on Geriatric Depression Scale among intervention group
- Increase in quality of life, mood, concentration, and confidence



Cognitive Stimulation + Exercise + Social Interaction*

- Group CS fulfils social interaction component
- Themed activities can include music and dance for exercise
- The more senses involved, the better the CS
- Chair exercises offer benefits
 - Lower blood pressure
 - Improved mood (less depression)
 - Increased or maintained muscle strength and flexibility
 - Improved cognitive function
 - Less brain atrophy
 - Improved sleep



Multidisciplinary Care

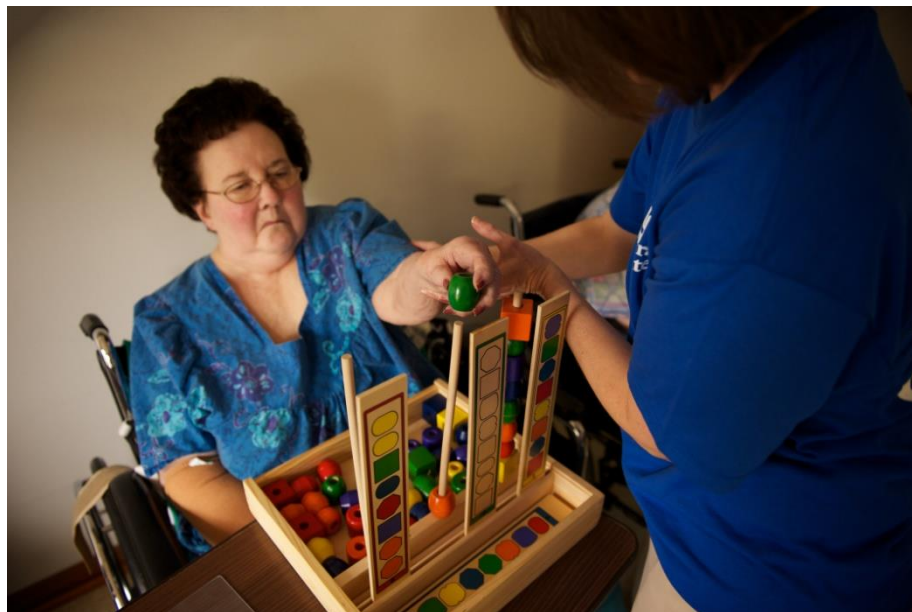
- Care plan is developed by more than one care provider (doctor, nurse, OT, psychologist)
- Multiple studies suggest that depression has a significant functional impact
 - More severe depression leads to more severe neurological impairment
- Psychological therapies improve depression but have little effect on ADLs



STAR – Linda Teri, PhD, University of Washington Iteri@uw.edu

Occupational Therapy

- Disease progression reduces quality of life and ability to engage in ADLs, leisure, and social activities
 - Improving and preserving ADLs are priority outcomes
- Specific OT activities reduce depression
 - Sensory stimulation
 - Environmental modification
 - Functionally oriented tasks
- OT is recommended by several dementia care guidelines



Animal Therapy

- Any activity spending time with animals
- Animal-assisted therapy (AAT) reduces depression symptoms in nursing home residents with dementia
 - Robotic animals yield same result
- AAT
 - Encourages physical activity
 - Improves communication
 - Reduces loneliness
 - Encourages release of endorphins



Reminiscence Therapy

- Activity that gives reminders of someone's past or family members
 - Uses all senses
 - Memories are evoked
 - Mental activity is stimulated
 - Props (videos, pictured, objects) are used
 - Can be individual or group
 - Classic therapy
 - Life review
 - Life-story book
- Proven to help older adults with depression
 - Limited studies in dementia but promising results



Psychotherapy + Reminiscence Therapy + Environmental Modification

- Environmental modification
 - Any change in living environment or place where care is provided
- Simple modifications can
 - Support independence in ADLs
 - Disguise exits and provide ways to wander
 - Encourage a variety of activities
- Increased control leads to decreased depression



Implications for Practice

Conclusion

- Watt, J., Goodarzi, Z., Veroniki, A., Nincic, V., Khan, P. A., Ghassemi, M., Lai, Y., Treister, V., Thompson, Y., Schneider, R., Tricco, A., & Straus, S. E. (2020). Comparative efficacy of interventions for reducing symptoms of depression in people with dementia: systematic review and network meta-analysis. *British Medical Journal*, 372:n532
 - Strong support for non-drug treatments
 - Massage and touch therapy
 - Cognitive stimulation therapy
 - Social interaction
 - Exercise
 - Anticholinergics with non-drug CS therapy

Questions



References

- Australian College of Fitness and Bodywork. (2017 April). 3 massages that can help dementia patients.
<https://acfb.edu.au/3-massages-that-can-help-dementia-patients/>
- Brenowitz WD, Zeki Al Hazzouri A, Vittinghoff E, Golden SH, Fitzpatrick AL, Yaffe K. Depressive Symptoms Imputed Across the Life Course Are Associated with Cognitive Impairment and Cognitive Decline. *J Alzheimers Dis.* 2021;83(3):1379-1389. doi: 10.3233/JAD-210588. PMID: 34420969.
- Burke AD, Goldfarb D, Bollam P, Khokher S. Diagnosing and Treating Depression in Patients with Alzheimer's Disease. *Neurol Ther.* 2019 Dec;8(2):325-350. doi: 10.1007/s40120-019-00148-5. Epub 2019 Aug 21. PMID: 31435870; PMCID: PMC6858899.
- Byers, A. L., & Yaffe, K. (2011). Depression and risk of developing dementia. *Nature Reviews. Neurology*, 7(6), 323–331.
<https://doi.org/10.1038/nrneurol.2011.60>

References

- Callahan, C.M., Boustani, M.A., Unverzagt, F.W., et al. (2006). Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: A randomized controlled trial. *Journal of the American Medical Association*, 295(18):2148–2157. doi:10.1001/jama.295.18.2148
- D'Onofrio, G., Sancarolo, D., Addante, F. et al. (2014). A pilot randomized controlled trial evaluating an integrated treatment of rivastigmine transdermal patch and cognitive stimulation in patients with Alzheimer's disease. *International Journal of Geriatric Psychiatry*, 30, pp. 965-975.
- Dudas R, Malouf R, McCleery J and Denning T, 2018. [Antidepressants for treating depression in dementia](#). Cochrane Database of Systematic Reviews, (8).
- Fox N, Black N, Livingston G, et al. [Trends in diagnosis and treatment for people with dementia in the UK from 2005 to 2015: a longitudinal retrospective cohort study](#). *The Lancet Public Health* 2017, 2(3):e149-e156

References

- Garfield, L. D., Dixon, D., Nowotny, P., Lotrich, F. E., Pollock, B. G., Kristjansson, S. D., Doré, P. M., & Lenze, E. J. (2014). Common selective serotonin reuptake inhibitor side effects in older adults associated with genetic polymorphisms in the serotonin transporter and receptors: data from a randomized controlled trial. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, 22(10), 971–979.
<https://doi.org/10.1016/j.jagp.2013.07.003>
- Fraker J, Kales HC, Blazek M, Kavanagh J, Gitlin LN. The role of the occupational therapist in the management of neuropsychiatric symptoms of dementia in clinical settings. *Occup Ther Health Care*. 2014 Jan;28(1):4-20. doi: 10.3109/07380577.2013.867468. PMID: 24354328; PMCID: PMC4209177.

References

- Frankenstein, L. L., & Jahn, G. (2020). Behavioral and occupational therapy for dementia patients and caregivers. *GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry*, 33(2), 85–100. <https://doi.org/10.1024/1662-9647/a000225>
- Fukushima, R., do Carmo, E. G., Pedroso, R., Micali, P. N., Donadelli, P. S., Fuzaro, G., Junior, Venancio, R., Viola, J., & Costa, J. (2016). Effects of cognitive stimulation on neuropsychiatric symptoms in elderly with Alzheimer's disease: A systematic review. *Dementia & neuropsychologia*, 10(3), 178–184. <https://doi.org/10.1590/S1980-5764-2016DN1003003>
- Forbes, D., Thiessen, E.J., Blake, C.M., Forbes, S.C., & Forbes, S. (2015). Exercise programs for people with dementia. *Cochrane Database Systematic Review*, (12):CD006489. doi: 10.1002/14651858.CD006489.pub3. Update in: *Cochrane Database Syst Rev*. 2015;(4):CD006489. PMID: 24302466.

References

- Hokanson, J., & Olmschenk, A. (2020). Does animal-assisted therapy reduce depression symptoms and agitation in nursing home residents with dementia?, *Evidence-Based Practice*, 23(8), pp 29-30. doi: 10.1097/EBP.0000000000000519
<https://doi.org/10.1186/s12888-019-2245-x>
- Kiosses, D. N., & Arean, P. A. (2010). Research on late-life depression and dementia care: across disciplines, across settings. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, 18(6), 457–459.
<https://doi.org/10.1097/JGP.0b013e3181db6dad>
- Laver, K., Clemson, L., Bennett, S., Lannin, N. A., & Brodaty, H. (2014). Unpacking the evidence: Interventions for reducing behavioral and psychological symptoms in people with dementia. *Physical & Occupational Therapy in Geriatrics*, 32(4), 294–309. <https://doi.org/10.3109/02703181.2014.934944>

References

- Lyketsos, C. G., Lopez, O., Jones, B., Fitzpatrick, A. L., Breitner, J., & DeKosky, S. (2002). Prevalence of neuropsychiatric symptoms in dementia and mild cognitive impairment: Results from the Cardiovascular Health Study. *Journal of American Medical Association*, 288(12). <https://jamanetwork.com/>
- Klimova, B., Toman, J. & Kuca, K. Effectiveness of the dog therapy for patients with dementia - a systematic review. *BMC Psychiatry* 19, 276 (2019).
- Moyle, W., Johnston, A.N., O'Dwyer, S.T. (2011). Exploring the effect of foot massage on agitated behaviours in older people with dementia: A pilot study. *Australian Journal of Ageing*, (3):159-61. doi: 10.1111/j.1741-6612.2010.00504.x. PMID: 21923711.

References

- National Collaborating Center for Mental Health. (2007). A NICE–SCIE guideline on supporting people with dementia and their carers in health and social care. National Clinical Practice Guideline, Number 42. National Collaborating Centre for Mental Health commissioned by the Social Care Institute for Excellence and National Institute for Health and Clinical Excellence.
<https://www.scie.org.uk/publications/misc/dementia/dementia-fullguideline.pdf?res=true>
- Ruthirakuhan, M., Luedke, A. C., Tam, A., Goel, A., Kurji, A., & Garcia, A. (2012). Use of physical and intellectual activities and socialization in the management of cognitive decline of aging and in dementia: a review. *Journal of Aging Research*, 384875.
<https://doi.org/10.1155/2012/384875>

References

- St. Louis University Geriatric Education Center (2020). <https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/cognitive-stimulation-therapy.php>
- Schaub, C., Von Gunten, A., Morin, D., Wild, P., Gomez, P., & Popp, J. (2018). The Effects of Hand Massage on Stress and Agitation Among People with Dementia in a Hospital Setting: A Pilot Study. *Applied psychophysiology and biofeedback*, 43(4), 319–332. <https://doi.org/10.1007/s10484-018-9416-2>
- Stringfellow, A. (2016). Care, and the cost of care by state. Dementia care costs by state: An overview of costs, types of dementia. Retrieved from <https://blog.caregiverhomes.com/dementia-care-costs-by-state-an-overview-of-costs-types-of-dementia-care-and-the-cost-of-dementia-care-by-state>

References

- Taylor W. D. (2015). Should antidepressant medication be used in the elderly?. *Expert review of neurotherapeutics*, 15(9), 961–963.
<https://doi.org/10.1586/14737175.2015.1070671>
- Teri, L., McKenzie, G. L., Pike, K. C., Farran, C. J., Beck, C., Paun, O., & LaFazia, D. (2010). Staff training in assisted living: evaluating treatment fidelity. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, 18(6), 502–509.
<https://doi.org/10.1097/JGP.0b013e3181c37b0e>
- Viggo Hansen, N., Jørgensen, T., & Ørtenblad, L. (2006). Massage and touch for dementia. *The Cochrane database of systematic reviews*, 2006(4), CD004989.
<https://doi.org/10.1002/14651858.CD004989.pub2>

References

- Watt, J., Goodarzi, Z., Veroniki, A., Nincic, V., Khan, P. A., Ghassemi, M., Lai, Y., Treister, V., Thompson, Y., Schneider, R., Tricco, A., & Straus, S. E. (2020). Comparative efficacy of interventions for reducing symptoms of depression in people with dementia: systematic review and network meta-analysis. *British Medical Journal*, 372:n532
- Woods B, O'Philbin L, Farrell EM, Spector AE, Orrell M.(2018). Reminiscence therapy for dementia. Cochrane Database of Systematic Reviews, 3. Art. No.: CD001120. DOI: 10.1002/14651858.CD001120.pub3.
- Xie, J. Brayne, C., Matthews, F. E., & Medical Research Council Cognitive Function and Ageing Study Collaborators (2008). Survival times in people with dementia: Analysis from population based cohort study with 14 year follow-up. *British Medical Journal*, online edition.