Apathy, depression and anxiety are common conditions experienced by people with dementia. They are known as psychological conditions because they can affect a person’s emotional and mental health.

This factsheet looks at how apathy, depression and anxiety can affect people with dementia. It also suggests ways for carers to help and looks at how these conditions can be treated.

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Apathy, depression and anxiety

Apathy

Many people feel short of ‘drive’ or ‘lose their ‘spark’ occasionally, but apathy is a persistent loss of motivation to do things, or a lack of interest in things. It is different from depression. Apathy is much more common among people with dementia than in older people without dementia. About 2–5% of older people without dementia have apathy at any one time, but about 50–70% of people with dementia have apathy.

A person with any type of dementia can have apathy but it is particularly common in frontotemporal dementia. Apathy can start at any stage of dementia but often develops early on. Many studies suggest that apathy becomes more common as dementia progresses. Once present, apathy tends to persist rather than come and go.

What are the symptoms of apathy?

A person with dementia and apathy will have less motivation, as well as some of the following changes:

- lack of effort or energy to do everyday tasks (such as personal hygiene)
- reliance on others to structure daily activities
- loss of interest or curiosity in new things (such as people or conversation)
- lack of concern about their own problems
- unemotional responses to news or personal events (seeming indifferent or detached).
Some of these symptoms (such as loss of interest in things and lack of energy) are also common in depression. It can be hard to know whether a person has depression or apathy – even for a doctor. The main difference is that a person with depression will have feelings of sadness, be tearful, feel hopeless or have low self-esteem – see the next section ‘Depression’. A person with apathy alone will not have these symptoms of low mood, more a feeling of being without energy or spark.

A person with apathy and dementia is often not concerned by their symptoms. However, these symptoms can make the person’s life less enjoyable and often put a strain on anyone helping them. Carers can feel frustrated because the person needs more support with daily tasks and because they seem so withdrawn and unresponsive.

**Causes of apathy**

One of the reasons that people with dementia are thought to develop apathy is damage to the brain’s frontal lobes. These control motivation, planning and sequencing of tasks. When someone withdraws, stops doing things and loses their confidence and abilities, their apathy can get worse and so they become even less motivated. It is important for anyone supporting the person to help them avoid this.

**Treating apathy**

Compared with depression and anxiety (see below), there is less evidence about what treatments do or do not help someone with apathy and dementia. Non-drug approaches should generally be tried first. According to recent research, music therapy, group art therapy and cognitive stimulation (when delivered by a trained professional) can all help.
What you can do to help a person with apathy: tips for carers

- Try tasks and activities that the person can do, enjoys and finds meaningful. A daily routine may help.
- Break tasks down into manageable chunks. Several smaller steps may be easier to take than one bigger step and help the person to feel like they are achieving things.
- You will often need to gently prompt or help the person, or start an activity (such as dressing). Offer lots of encouragement to keep them engaged, but don’t fuss over them. Be positive and focus on what they have achieved.
- Don’t blame the person for being ‘lazy’, unhelpful or not caring – it’s not their choice. If you feel frustrated, try to remain calm. The person may pick up a negative mood.
- Look after yourself: take regular breaks and see if replacement (respite) care is an option. Talk to someone you trust or join a support group, perhaps online. Others may have helpful tips to share.

Drugs play only a small part in the treatment of apathy. Some people who are already taking a cholinesterase inhibitor (donepezil, rivastigmine or galantamine) for Alzheimer’s disease or mixed Alzheimer’s-vascular dementia will have an improvement in their motivation, as well as in memory and concentration.

A person with apathy may also be offered an antidepressant drug, although there is very little evidence that common antidepressants bring any benefits for apathy in Alzheimer’s disease, mixed or vascular dementia. There is some evidence that these drugs make apathy worse.

2–5%

About 2–5% of older people without dementia have apathy at any one time
50–70%

About 50–70% of people with dementia have apathy at any one time.

It can be hard to know whether a person has depression or apathy – even for a doctor. The main difference is that a person with depression will have feelings of sadness, be tearful, feel hopeless or have low self-esteem – see the next section ‘Depression’. A person with apathy alone will not have these symptoms of low mood, more a feeling of being without energy or spark.

1 in 5

At least one in five people in the UK will experience depression at some time in their lives.

Depression

Most people feel low or down from time to time, but this is not the same as being depressed. Depression is a condition that lasts for longer periods. A number of feelings, such as sadness and hopelessness, dominate a person’s life and make it difficult for them to cope. People with depression may also experience physical symptoms, such as loss of energy and appetite changes. Physical symptoms of depression are more common in older people with the condition.

At least one in five people in the UK will experience depression at some time in their lives. It is more common among people with dementia (20–40% of whom may have depression), particularly those who have vascular dementia or Parkinson’s disease dementia. Depression is often diagnosed in the early stages of dementia, but it may come and go, and may be present at any stage. Depression is also common among family carers supporting a person with dementia.
What are the symptoms of depression?
Depression affects people in different ways and to different degrees. Doctors may talk about mild, moderate and severe depression. Some of the more common symptoms include:

- a sad, hopeless or irritable mood for much of the time
- a loss of interest or pleasure in activities that were once enjoyed
- feelings of low self-esteem, worthlessness or undue guilt
- feelings of isolation and of being cut off from other people
- sleep disturbance, such as early morning waking
- problems with remembering, concentrating or making simple decisions
- increased agitation and restlessness
- tiredness or loss of energy
- eating too little or too much, with weight loss or gain
- aches and pains that appear to have no physical cause
- thoughts of death and suicide.

Some of these symptoms (such as problems with memory or concentrating, and withdrawal) are similar to those experienced by people with dementia. This is why assessment of someone for possible dementia will usually include ruling out depression first, in case depression alone, rather than dementia, is causing their symptoms.

A person with both dementia and depression will be struggling with two lots of difficulties. They may find it even harder to remember things and may be more confused or withdrawn. Depression may also make behavioural changes worse in people with dementia, causing aggression, problems sleeping or refusal to eat. In the later stages of dementia, depression tends to show itself in the form of depressive ‘signs’, such as tearfulness and weight loss.
Anxiety

Anxiety is a normal feeling that everyone experiences now and again. In some people, however, these feelings can be very strong and persistent. This can interfere with a person’s everyday life.

Anxiety is the main symptom of several different conditions, including generalised anxiety disorder (GAD), panic disorder, phobias and obsessive compulsive disorder (OCD).

**Generalised anxiety disorder (GAD)** – people with GAD feel anxious about a wide range of issues and situations. They find it hard to control their anxiety and they feel anxious most of the time.

**Panic disorder** – this is characterised by panic attacks in which the person will get sudden, intense attacks of anxiety. The attack may be accompanied by feelings of losing control (or ‘going crazy’) and feelings that they are about to die, as well as physical symptoms such as trembling and sweating.

**Phobias** – a phobia is an intense, irrational or disproportionate feeling of fear about a particular object or situation. Common phobias include social phobia (a fear of being around others) and agoraphobia (a fear of being in situations or environments such as public spaces, where escape might be difficult or that help wouldn’t be available if things go wrong).

**Obsessive-compulsive disorder (OCD)** – a person with OCD is unsettled by thoughts and obsessive worries that make them feel anxious. Their anxiety may be temporarily relieved when they carry out a compulsive behaviour or ritual (for example, washing their hands or carrying out an activity a certain number of times).
About one in 10 people will experience an anxiety disorder at some point in their lives and many people will have more than one form. Anxiety is more common in people with dementia than those without, affecting between 5% and 20%. Like depression, anxiety is thought to be more common in vascular dementia, and probably also in Parkinson’s disease dementia, than in Alzheimer’s disease. Anxiety is common throughout the different stages of dementia.

What are the symptoms of anxiety?
There is a large overlap in the symptoms of the different anxiety disorders. General symptoms of anxiety include:

- **Psychological symptoms** – feeling extremely worried, tired, uneasy and irritable, experiencing feelings of dread and having problems concentrating
- **Physical symptoms** – fast or irregular heartbeats (palpitations), shortness of breath, excessive sweating, dry mouth, trembling, dizziness, nausea, diarrhoea, stomach ache, headache, insomnia, frequent urination, excessive thirst, muscle tension or pains.

People with dementia and anxiety may also have behavioural changes including agitation, hoarding, seeking constant reassurance, not wanting to be left alone or closely following their carer or family member around. The person may also appear restless and pace or fidget. See ‘Treating anxiety’ below for ways of helping someone who is experiencing anxiety.
Causes of depression and anxiety

Many of the things that can cause people to feel depressed can also cause people to feel anxious, and vice versa. The exact causes of these conditions vary from person to person and there are often several contributing factors. People with a past history of depression or anxiety are more likely to have them again.

Possible causes of depression and anxiety include:

- traumatic or upsetting events – these can trigger high levels of anxiety that continue long after the event is over
- the effects of certain illnesses or the side-effects of medication – agitation may be caused by pain, hunger or an infection, for example
- lack of social support or social isolation – perhaps because the person can no longer get out as much
- bereavement
- lack of meaningful things to do, with feelings of boredom and aimlessness
- feeling stressed or worried over issues such as money, relationships or the future
- having a genetic predisposition to depression or anxiety.

The causes of depression and anxiety in someone who has dementia can be similar to those for someone without dementia. However, in the early stages of dementia these conditions may be linked directly to a person’s worries about their memory and about the future. People often retain their insight and awareness better in vascular dementia than in Alzheimer’s disease. This may help to explain why depression and anxiety are more common for people with vascular dementia. Damage to nerve pathways caused by reduced brain blood flow (vascular disease) is thought to cause depression in some people. Chemical changes in the brain, caused by the dementia, may also lead to depression or anxiety.
People living in care homes seem to be particularly at risk of depression. Anxiety in people living in care homes has been linked to unmet needs, including a lack of daytime activities and a lack of company. As dementia progresses, people become more disorientated, more forgetful and worse at thinking things through. This constant struggle to make sense of the world around them can therefore be an underlying cause of anxiety.

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Treating depression

A person with depression should be offered a range of treatments, depending on how severe or long-standing their depression is. These may include self-help, talking therapies or antidepressant medication.

For mild depression, which may lift by itself over time, the preferred approach is often self-help (for example, exercise) or a support group. If someone has severe or persistent depression, the GP will generally prescribe antidepressant medication, together with or followed by a referral for talking therapy, such as cognitive behavioural therapy (CBT). Someone with moderate depression may be offered a talking therapy, an antidepressant or both.

These approaches – especially an antidepressant combined with a talking therapy – are often effective, but they all take time to work: a few weeks, rather than a few days. However, this may vary for a person with dementia. For example, a person with dementia may not be able to benefit from talking therapies because of their reduced attention, communication, memory or reasoning. Use of antidepressants as the first treatment for people with dementia is also widespread, but such drugs seem to be much less effective in people with dementia than in people who don’t have dementia.
Guided self-help, activities and lifestyle changes

These approaches for dementia with mild depression do not require a counsellor, psychotherapist or doctor to deliver them, although professional guidance is still likely to be very helpful. Research shows that people with depression and dementia may respond to:

- regular physical exercise, such as short walks, tai chi or whatever is appropriate to the person’s ability to move or what they enjoy
- a reassuring daily routine
- regular activities with other people - social isolation can make depression worse
- increased time spent doing enjoyable activities – examples include reminiscence and life story work (in which the person sits with someone to build a scrap book or photo album of their life)
- more one-to-one interaction, such as talking, hand holding, or gentle massage, if appropriate
- changes to the person’s environment – for example, reducing bright lights, loud noises or avoiding large groups of people.

Support groups, where people can talk to others who are going through a similar experience, may also be very helpful. For information about groups near you, contact Alzheimer’s Society’s National Dementia Helpline on 0300 222 1122.

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Psychological therapies (talking therapies)

Psychological therapies or talking therapies encourage people to talk about their feelings. Talking therapies are based on a model of how the mind works and are delivered by a counsellor, psychotherapist or other professional with training and a recognised qualification.

There is some evidence that sessions of talking therapy, given over several weeks, reduce depression and anxiety in people with dementia, particularly in the early stages of the condition. The therapy usually needs to be modified to suit the person’s level of communication, understanding and memory. A therapist who has experience of working with people with dementia is therefore likely to be best. Talking therapies may be less appropriate in the later stages of dementia, when people are likely to have problems with attention, communication, understanding and memory.

There are many different types of talking therapies available, including counselling, interpersonal therapy and CBT. The type of therapy that will be most suitable will depend on what the person would like to get out of therapy and the stage of their dementia. However, suitable talking therapies are not always available in a person’s area, and older people are less likely to receive a talking therapy than younger people, particularly those with depression living in care homes. For more information see factsheet 445, Talking therapies (including counselling, psychotherapy and CBT).
Antidepressant medication

It is thought that depression is caused by low levels of certain chemicals (known as ‘neurotransmitters’) in the brain. Antidepressants are thought to increase the levels of these chemicals, which helps to restore brain function. Someone with depression and dementia is likely to be offered antidepressant medication, particularly if the depression is severe or has not responded to other treatments. However, the evidence that antidepressants work in people with dementia is not conclusive: two research trials published since 2010 reported no overall benefits on symptoms of depression from two widely-used drugs in people with Alzheimer’s disease.

When someone takes antidepressants, the dose will start low and gradually increase, and there may be a delay of several weeks before the person feels any benefits. There may also be side-effects to begin with, possibly more often than in a younger person, but these should lessen as the body adjusts to the drugs. If the side-effects continue, the doctor may decide to change the dose or provide an alternative antidepressant. Sometimes the person will need to try a few different types of antidepressant before they find one that is effective for them. Antidepressants are usually taken for at least six months and often longer. It is important that the person takes the medication as prescribed, even if the drugs do not appear to be working.

Some people find that they have difficulty coming off antidepressants and may experience withdrawal symptoms, such as increased anxiety, if their antidepressants are suddenly stopped. For this reason, antidepressants should always be withdrawn slowly.
Apathy, depression and anxiety

There are many different types of antidepressants, including:

- **SSRIs and SNRIs** – SSRI (selective serotonin reuptake inhibitor) and SNRI (serotonin-noradrenaline reuptake inhibitor) drugs are commonly used treatments for depression. This is because their side-effects are usually less severe than those of other drugs, although they can produce headaches and nausea (especially in the first week or two of treatment). Most people with dementia who are prescribed an antidepressant are currently offered an SSRI (such as sertraline or citalopram) first.

- **Older antidepressants** – these include tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs). They are less commonly used and are likely to increase confusion in people with dementia. Side-effects are common, especially in older people. A strict diet must be followed when taking MAOIs, and these drugs should not be taken by people who have had a stroke or those with a history of heart disease.

**Treating anxiety**

Treatment of anxiety, like treatment of depression, can involve a range of approaches depending on the person’s needs. You can help people with dementia with mild anxiety by making time to listen and provide reassurance. Other ways of helping include making adjustments so that their living environment is calmer and safer, and they have an improved structure to everyday life (including exercise and activities which have meaning for the person).

People with more severe and persistent anxiety can respond well to psychological therapies such as CBT (see ‘Treating depression’ above). There is also some evidence that music therapy with a qualified therapist reduces agitation, which can be a symptom of anxiety.

**It is important to see the doctor if a person with dementia is behaving in an unusual or worrying way, or has deteriorated more rapidly than expected. These changes could be caused by apathy, depression or anxiety, or could be due to an illness or the effects of medication.**
Medication can also be helpful. Common medications used to relieve anxiety include:

- **Antidepressants** – these drugs can help relieve anxiety as well as depression, although the evidence for their benefit in anxiety is limited. An SSRI, such as sertraline, is recommended to be tried first. See above for information on the different types of antidepressants.

- **Benzodiazepines** – these are very effective at treating anxiety but should only be used for a short period (up to two weeks). When used for longer periods they are addictive and may cause unpleasant withdrawal symptoms when a person stops taking them. They are not usually suitable for people with dementia as they can cause excessive sedation (drowsiness), unsteadiness and a tendency to fall, and they may worsen confusion and memory problems.

- **‘Z’ drugs (non-benzodiazepines)** – these drugs are used to treat sleep problems, which are common in both depression and anxiety. They have similar effects to benzodiazepines. Examples include zaleplon, zolpidem and zopiclone.

- **Buspirone** – this is a specific anti-anxiety drug. It works in a similar way to benzodiazepines but does not cause drowsiness and is not addictive. It should, however, still only be used for a short period of time.

- **Antipsychotics** – Antipsychotics are sometimes used for severe or persistent anxiety, but should generally be avoided for treating anxiety in people with dementia. For more information see factsheet 408, *Drugs for behavioural and psychological symptoms in dementia*. 
Helping the person with feelings of depression and anxiety: tips for carers

Someone who is feeling depressed or anxious will often find the following helpful:

- Talking about their feelings – if someone is feeling depressed or anxious, or something very upsetting or traumatic has happened to them, they may find it helpful to talk to someone close to them about it. (Patience and understanding will be more helpful than trying to get the person to ‘cheer up’.)

- Support to help them maintain social contact with other people – this will help them to feel less isolated.

- Persevering with treatment – those close to the person should encourage them to keep taking their medication or seeing their therapist even if improvement feels slow at the start.

- Keeping active – physical exercise is good for relieving feelings of anxiety and depression, and can also help people with sleep problems and apathy. Supporting the person to do other activities that they enjoy will often also help.

- Eating a healthy diet – a poor diet can contribute to feelings of anxiety and depression, as can alcohol and caffeine. It is therefore a good idea to try to eat a healthy diet and not drink too much alcohol or caffeinated drinks.

Some people may also want to try complementary and alternative therapies. If a person would like to access these, they should first speak to their doctor. Complementary and alternative therapies that may be of benefit include St John’s wort, aromatherapy, massage and bright light therapy.
Consulting the doctor

It is important to see the doctor if a person with dementia is behaving in an unusual or worrying way, or has deteriorated more rapidly than expected. These changes could be caused by apathy, depression or anxiety, or could be due to an illness or the effects of medication.

In order to diagnose apathy, anxiety or depression, the doctor will talk to the person with dementia and their carer. They will try to assess the person’s behaviour, mood and any changes that have occurred (for example, have they become more agitated or do they have less energy?)

It can be difficult for a doctor to diagnose depression in a person with dementia because the symptoms of depression and dementia are so similar. Symptoms of apathy and depression can also overlap. People with dementia may also have difficulty communicating their low mood or feelings of anxiety to others. Because of this, a person’s dementia is put down to depression, and occasionally people who are depressed are thought to have dementia. Key differences in symptoms between depression and dementia are as follows:

- Depression tends to develop much more quickly than dementia (over weeks or a few months).
- Problems with speech, reasoning, and orientation in time and space are unusual in depression but are common in people with dementia.
- A person with depression may occasionally say they can’t remember things but will remember when prompted, whereas a person with dementia (particularly Alzheimer’s disease) will be forgetful and will often try to cover up memory loss.
- Where people with depression have very bad impairments in their reasoning and memory (for example, when depression is severe), this is mainly due to poor concentration. These problems are reversible with treatment or when the depression lifts, which is not the case with dementia.
Other useful organisations

British Association for Counselling and Psychotherapy (BACP)
BACP House
15 St John’s Business Park
Lutterworth
Leicestershire LE17 4HB
01455 883 300
bacp@bacp.co.uk
www.bacp.co.uk

National body representing counsellors and psychotherapists. Can help you to find a suitable counsellor in your area.

Counselling Directory
Coliseum, Riverside Way
Camberley
Surrey GU15 3YL
0333 3447 990
www.counselling-directory.org.uk

Website that includes a searchable database of counsellors and psychotherapists who are members of a recognised professional body. Also useful information about how talking therapies might be able to help.

Mind
Mind
15–19 Broadway
Stratford
London
E15 4BQ
0300 123 3393 (helpline 9am–6pm weekdays)
info@mind.org.uk
www.mind.org.uk

Charity offering information and advice on all aspects of mental health. Provides a range of support services through local Mind associations.
Alzheimer’s Society National Dementia Helpline
England, Wales and Northern Ireland:
0300 222 1122
9am–8pm Monday–Wednesday
9am–5pm Thursday–Friday
10am–4pm Saturday–Sunday

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