Addressing Difficult Behaviors in Dementia

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Objectives
By the end of the session, you will be able to:

1) Explain the role of pain management in ameliorating difficult behaviors

2) Discuss helpful methods for addressing many difficult behaviors in the person with dementia

3) Understand the implications for PTSD and its management in behavioral and psychological symptoms of dementia.

Dementia—Brain Failure

Impairment in:
- Memory
- Information processing
- Judgment

Signs and Symptoms of Dementia

- Memory loss; Confusion;
- Disorientation to time or place;
- Getting lost in familiar locations;
- Impairment in speech/language;
- Trouble with time relationships / sequence of events;
- Diminished insight; Poor judgment/problem solving;
- Changes in sleep and appetite;
- Mood/personality/behavior changes;
- Wandering;
- Deterioration of self care/hygiene;
- Difficulty performing familiar tasks, functional decline
Dementia Diagnosis
(Neurocognitive Disorder)

Evidence from the history and clinical assessment that indicates significant cognitive impairment in at least one of the following cognitive domains:

- Learning and memory (impaired ability to learn or acquire and remember new information—3 items in 5 minutes)
- Executive function (impaired reasoning and handling of complex tasks, poor judgment)
- Language
- Perceptual-motor function
- Complex attention
- Social cognition (changes in personality, behavior or comportment)
  - Recognize thoughts, beliefs, and intentions in oneself and others (often referred to as theory of mind)
  - Identify basic emotions such as happiness, sadness, fear, anger, disgust, and surprise in others (emotion processing)
  - Make decisions by weighing choices associated with variable rewards and punishments

Dementia

The impairment must be acquired and represent a significant decline from a previous level of functioning

The cognitive deficits must interfere with independence in everyday activities

The disturbances are not occurring exclusively during the course of delirium

The disturbances are not better accounted for by another mental disorder (e.g., major depressive disorder, schizophrenia)

Cognitive impairment established by history-taking from the patient and a knowledgeable informant; and objective bedside mental status examination or neuropsychological testing

Dementia Diagnoses

- Alzheimer’s Disease: 60-80%
  - Includes mixed AD + VD
- Lewy Body Dementia: 10-25%
  - Parkinson spectrum
- Vascular Dementia: 6-10%
  - Stroke related
- Frontotemporal Dementia: 2-5%
  - Personality or language disturbance
Alzheimer’s is Insidious

Accumulation of neuropathology in the brain
10-20 years before symptoms appear

Alzheimer’s Disease

[Video link]

End Stage Dementia

Neuropsychiatric symptoms common:
- 60% of community dwelling patients with dementia
- > 80% of nursing home residents with dementia

Nearly all patients with dementia will suffer from mood or behavioral symptoms during the course of their illness

Behavioral and Psychological Symptoms of Dementia

Ferri et al., 2005; Jeste et al., 2008

86% with Eating Problems
25% with pain
Mood and Behavioral Symptoms

Agitation, anxiety, elation, irritability, depression, apathy, disinhibition, delusions, hallucinations, sleep changes, appetite changes, wandering

5 Most Difficult Behaviors

- Hallucinations
- Hostility / Aggression
- Irritability
- Delusions
- Extreme social withdrawal

Identify Reversible Causes

- Unmet needs
  - Boredom
  - Meaning, purpose
  - Over/under stimulation
  - Pain/discomfort
  - Safety
  - Environmental stressors

- Caregiver reactions
  - Limited knowledge about disease process or behaviors

Behavior Is Communication

Your first questions should be:
- Does this really require treatment?
- Who is most affected? The patient? Caregivers?
Step 1: Define behavior
Step 2: Categorize target symptom
Step 3: Identify reversible causes
Step 4: Use non-drug interventions first to treat target symptoms

Step 4: Non-pharmacologic Interventions

Think like a behavioral analyst
- Detective work, ask:
  - Who (is involved/present)
  - What (exact description, be specific)
  - When (time dependent? only in morning? triggers?)
  - Where (location specific?)
  - Why (what happens right before, right afterwards? what do family think is cause?)
  - ABC approach (antecedent, behavior, consequence)

Teach family caregivers to:
- Validate ➔ Join ➔ Distract
- Understand that behavior = communication
- Ask themselves:
  - Is this really a problem, and for whom?
  - What is the feeling or underlying message this behavior is trying to communicate?
  - How can I address the underlying need?
  - How long will this solution last?

Validation

Patients with dementia should be accepted as they are: we should not try to change them.

Listening with empathy builds trust, reduces anxiety, and restores dignity.

Painful feelings that are expressed, acknowledged, and validated by a trusted listener will diminish. Painful feelings that are ignored or suppressed will gain in strength.
Validation

There is a reason behind the behavior of those with dementia, which may be one or more of the following needs:

- Unfinished issues
- To make sense out of unbearable reality
- Need for self worth
- Need to be heard
- Need to belong
- Etc.

George’s EOL Philosophy

So, what is it that is really important:

1. The Meaning of One's Life
2. Clarify Family Values
3. Heal Relationships, while you still can

As it always is in Behavioral Health

Its complicated!!!
The ever present issue of delirium!!

Sudden and new onset psychomotor behavioral disturbances such as hypoactivity, hyperactivity with increased sympathetic activity, and impairment in sleep duration and architecture.

Variable emotional disturbances, including fear, depression, euphoria, or perplexity
1. Acute Onset and Fluctuating Course (can lead to confusion with Lewy Bodies Dementia)
2. Inattention (distractibility)
3. Disorganized thinking
4. Altered Level of consciousness (Lethargic, hyperalert, etc.)

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Delirium—other features

Psychomotor agitation
Lethargy
Sleep-wake reversals
Irritability
Anxiety
Emotional lability
Hypersensitivity to lights and sounds

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Develops over hours to days
Can last from 3 days-3 months
Varies each day
Varies with time of day—worse in evenings ("sundowning")

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Not right
Agitated
Drowsy
Euphoria
Perplexity
50% have underlying dementia
Delirium—exploring the etiology

Drugs: 1/3
Infection
Trauma
Constipation
Heart Failure
Other cardiac/respiratory
Withdrawal benzodiazepines
New environment
Chaotic environment

Delirium—principles of management

Avoid factors that could aggravate
Treat any acute illness found
Provide Support
Manage dangerous behavior (with antipsychotic?), so you can successfully address the first three

Delirium—support

- Frequent reassurance
- Touch
- Verbal orientation with someone familiar
- Hydration
- Avoid restraints
- Mobilize
- Reduce noise
- Increase sensory stimulation
- Proper lighting
- Treat pain
- Keep safe

Delirium—urgent if:

- Associated with abnormal vital signs
- New hypoxia or dyspnea
- Patient appears to be a danger to self or others
Delirium—prevention (avoiding aggravating dementia)
Avoid dehydration; Avoid constipation;
Avoid polypharmacy; Avoid Foleys;
Avoid Restraints; Avoid Anticholinergics;
Encourage mobility;
Treat pain; Correct sensory losses;
Establish orientation protocols;
Utilize non-pharmacologic sleep aids

Examples of Anticholinergic Medications
- Tricyclic antidepressants
- Antihistamines
- Muscle relaxants
- Ditropan
- Reglan

Other forms of nonpharmacological management of BPSD
- Reality orientation
- Reminiscence therapy
- Art therapy
- Music therapy
- Activity therapy
- Aromatherapy
- Bright-light therapy
- Multisensory approaches

Activity planning
- Tap into preserved capabilities and previous interests
- Involve repetitive motion

Communication
- Slow down, offer simple choices
- Help individual find words for self expression

Simplify Environment
- Remove clutter, minimize stimuli during activity
- Establish routines

Caregiver support
- Self care, minimize confrontation/arguing with loved one
- Identify support network
Medication Management

**Delirium**
- Antipsychotic: if needed
- Not effective in terminal delirium, so then may want to consider a benzodiazepine if seems anxious

**BPSD**
- Narcotic least likely to cause harm.
- Pain is etiology 25% of time
- Watch for pain behaviors
- No indication for antipsychotic, but may be helpful if psychotic (rare), or a danger to self or others
- Benzodiazepines: harmful except in terminal delirium

PTSD manifestations in EOL Dementia

Questions/thoughts/ideas??

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