

Understanding Challenging Behaviors in Dementia

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Conflict Disclosure

- Janssen-Ortho
- Eli-Lilly
- Astra Zeneca
- Pfizer

Resources

- IPA website-BPSD Education Pack
www.ipa-online.org
- Putting the P.I.E.C.E.S. Together. 1st Ed:
Nova Scotia 2004-05.
- Radin, Lisa & Gary (2003) What If It's Not
Alzheimer's?

Dementia/BPSD

- Overview
 - Definition of dementia
 - Brief review of clinical picture of dementia
 - Discussion of BPSD
 - Discussion of resistance vs aggression
 - Strategies for preventing, assessing and treating behavioral problems in the context of dementia

Dementia/BPSD

- Objectives

- A renewed sense of belief that caregivers and clinicians can have a positive impact on the lives of the people that we care for.
- An understanding of the factors which contribute to behavioral challenges in dementia.
- An appreciation that although we sometimes require the use of pharmacotherapy that we always need to consider the personal, environmental, interpersonal and biologic factors contributing to the behavioral concerns.

Definition of the Syndrome

- Dementia

- Multiple cognitive losses:

- Memory loss
- Aphasia
- Apraxia
- Agnosia
- Disturbance in executive function

- These lead to functional decline

Clinical Features of AD (mild Stage) MMSE 21-30

Cognition	Function	Behavior
Recent memory	Work	Apathy
Word finding	Money	Withdrawal
Problem solving	Cooking	Depression
Judgement	Housekeeping	irritability
Calculation	Reading/writing	
	Hobbies	

Clinical Features of AD (moderate stage) MMSE 10-20

Cognition	Function	Behavior
Recent memory	IADL loss	Delusions
Language (names)	Misplacing objects	Wandering
Insight	Getting lost	Agitation
Orientation	Difficulty dsgr (cues helpful)	Insomnia
Visuospatial ability		Depression
		Social skills unaffected

Clinical Features of AD (Severe Stage) MMSE 0-10

Cognition	Function	Behavior
Disoriented	Dependent for basic ADL's:	Agitation-
Apraxia (difficulty with usual activities)	Dressing,Eating	Verbal
Decreased language	Bathing, Walking	Physical
	Continence	insomnia

Functional Assessment and Staging Tool (FAST)

- Reisburg
- Works best with BCRS (and Alzheimers Disease)
- 1-7

FAST

- Stage 1: no functional decrement
- Stage 2: Subjective word finding difficulties
- Stage 3: Decreased function in demanding employment
- Stage 4: Decreased ability to perform complex tasks such as finances/planning complex meals

FAST

- Stage 5: Requires assistance choosing proper clothing
- Stage 6: a-e
 - A: difficulty putting on clothes
 - B: Requires assistance bathing
 - C: inability to handle mechanics of toileting
 - D: urinary incontinence
 - E: fecal incontinence

FAST

- Stage 7: A-F

- A: ability to speak is limited to ~6 words
- B: Intelligible vocabulary limited to single word
- C: Ambulatory ability lost
- D: Ability to sit up (unaided) lost
- E: Ability to smile lost
- F: ability to hold head up (unaided) lost

Dementia

- Types of dementia:
 - Alzheimer's
 - Vascular
 - Mixed AD/Vascular
 - Lewy Body Dementia
 - Frontotemporal dementia
 - Dementia of Parkinsons, Huntingtons, HIV

Dementia

- Each has its own pathology and defining characteristics.
- Each has its own presentation although often in the early stages it can be very difficult to differentiate between them.
- Likewise in the late stages of dementia the impairment is global.

Dementia/BPSD

- Behavioral and Psychological Symptoms of Dementia
- Behavioral: Based on observing the pt
 - Agitation
 - Screaming
 - Restlessness
 - Wandering
 - Sexual disinhibition
 - cursing

Dementia/BPSD

- Psychological: Assessed at interview:
 - Anxiety
 - Depression
 - Hallucinations
 - Delusions
 - Apathy

BPSD/Frequency

- Personality Changes
 - Up to 90%
- Affective
 - Depression up to 80%
 - Mania 3-15%
- Agitation
 - Agitated behavior up to 50%
 - Aggression up to 20%

BPSD/Frequency

- Psychosis
 - Delusions 20-73%
 - Misidentifications 23-50%
 - Hallucinations 15-49%

BPSD/Common Causes

- Misinterpretation:
 - Environment
 - Caregiver
 - Signals/cues
- Delirium: increases confusion
- Pain: bone, dental/oral, skin breakdown, rash
- Fear

BPSD/Common Causes

- Fatigue
- Boredom
- #1 cause of aggression towards caregivers is intimate care (bathing, toileting, dsg, feeding).



Resistance vs Aggression

- Resistance by definition is “opposition” or “counteracting force” “the natural ability of an organism to remain unaffected by a noxious agent in its environment”
- Resistance is an attempt to protect the self from harm and in cognitive impairment may be an instinctual reaction to not understanding the environment/expectations.



Resistance vs Aggression

- Aggression includes in its definition behaviors that are “angry and destructive and are intended to be injurious, physically or emotionally and aimed at domination.
- Aggression also implies offensive action where resistance implies defensive action.
- Aggression can occur without provocation, resistance must be in relation to an action.

Prevention of BPSD

- Behavioral problems are often triggered by unmet needs and a lack of understanding of the individual with dementia.
- Gathering information about the person whom you are caring for/treating, can be vital in understanding, preventing and ultimately treating behavioral problems that may occur in the context of their illness.

Assessment of BPSD

- What specifically is the problem?
- Why is it a problem now?
- Whose problem is it?
- Is there a safety risk?

Assessment of BPSD

- What is the problem?
 - Description using common language.
 - Cohen-Mansfield Agitation Inventory
 - Physically aggressive
 - Physically non-aggressive
 - Verbally aggressive
 - Verbally non-aggressive
 - Frequency(never-weekly-daily-hourly-constant).

Assessment of BPSD

- Why is it a problem now?
 - Is it new?
 - Is it a recurrence of an old behavior previously under control?
 - Is it of increased frequency or severity?
 - Is there something (or someone) new on the scene?
 - Has something else changed?

Assessment of BPSD

- Whose problem is it?
 - Is the behavior problematic for the pt?
 - Is the behavior endangering/irritating/upsetting to other pts/residents/family members/visitors?
 - Does the behavior upset staff or interfere with care? If so does it happen on all shifts? With all staff? Just one staff? Just women? Just men? Only with a bath? Etc, etc.

Assessment of BPSD

- What is the degree of risk?
 - More problematic in community where we look at RISKS (R-roaming, I-imminent physical risk from fire, falls, frailty; S-suicide; K-kinship relationships (abuse/neglect); S-self neglect, substance abuse, safe driving.
 - In LTC we look at risk of suicide, elopement and aggression to others. (Often very difficult situation because of conflicting perspectives)

General Approach to New/Upsetting Behaviors

- Is this behavior “appropriate” for the type and stage of dementia?
- Is it understandable based on the persons functional abilities? Is the person overwhelmed?
- Is the behavior understandable based on who this person is (and has always been)?

General Approach to New/Upsetting Behaviors

- Check for underlying causes:
 - Unmet needs(toileting, hunger, thirst etc)
 - Pain
 - Delirium (meds, infection)
 - Constipation
- Reverse/Treat underlying causes.

General Approach to New/Upsetting Behaviors

- Be aware of the persons function abilities.
- Check your communication style:
 - Speak slowly, clearly, respectfully.
 - Use simple instructions, one step at a time.
 - Watch your body language/their body language.
 - Learn all you can about dementia and specifically about how it effects this person.
 - Remember to use hearing aids, glasses.

Physical Environment

- Good Ideas:
 - Places to wander
 - Digital or hidden locks
 - Electronic bracelets/wanderguards
 - Double bolts on doors
 - Half doors
 - Stage appropriate toys, books, puzzles, TV shows.

Physical Environment

- Good ideas:
 - Give meals in a style that suits ability-ie may need to use finger foods.
 - Flexible routine.
 - Things to do!!!
 - Music.

Physical Environment

- Not a good idea:
 - Highly patterned wallpaper.
 - Mirrors.
 - Loud call bells/paging systems.
 - Frequent room changes/redesign.
 - CNN/Soap Operas.
 - Rigid routines.

The ABC's of Behavioral Intervention

- A-Antecedent: what was happening before the incident or behavior occurred? Who was there? What were the circumstances?
- B-Behavior: What, when, where? What (be specific) happened? How long did it last? When did it happen? Where did it occur?

The ABC's of Behavioral Intervention

- C-Consequence: the response to behavior. What happened? Who did what to whom?
- Very important to document both successful and unsuccessful interventions.

Top Ten BPSD Not Amenable to Meds

- Wandering
- Inappropriate urination/defecation
- Inappropriate dressing/undressing
- Annoying activities (pulling on locked doors etc)
- Frequent repetition
- Hiding/hoarding
- Pushing wheelchair bound co pt
- Eating inedibles
- Inappropriate isolation
- Tugging at or removal of restraints

Behavioral Challenges/Wandering

- Little efficacy of medications
- Check re: akathisia (which increases need to pace)
- Was this person a habitual walker/runner/doer?
- Is this behavior really a “problem”
- Who’s problem?

Behavioral Challenges/Wandering

- At home:
 - Double locks on doors/move lock out of sight
 - Wandering Registry
 - Adequate daytime physical activity
 - Things to do/distraction
 - If planning a move involve the less demented pt. In a more impaired pt you want to move the person quickly with little fuss

Challenges/Repetitive Questions

- Where's my wife? What do I do now? Etc Etc....
 - Consistently ignoring repeated questions works for some
 - Distraction with food, presence, activity
 - React/respond to the emotional content rather than the words
 - Controversy over the “therapeutic use of lies”

Behavioral Challenges/Screaming

- Screaming usually occurs in the later stages of dementia
- Broken brain
- Careful assessment if new onset
- May result from lack of/excess of environmental stimulation
- Little efficacy of medication

Behavioral Challenges/Screaming

- Non-pharmacological management:
 - Increase socialization if appropriate
 - Increase auditory stimulation (if decrease is suspect)—music works well
 - Simulated presence therapy???
 - Monitor behavior carefully for triggers and rectify accordingly

Challenges/Verbal&Physical Aggression

- Try to intervene early
- Try to avoid situations that are known to be provoking for the individual
- Use a calm and reassuring voice
- **AVOID ARGUING** or **CONFRONTATION** when agitated
- Approach slowly, from the front

Challenges/Verbal&Physical Aggression

- Use touch judiciously-can be perceived as comforting or provoking
- Use non-threatening stance-should be at eye level
- Use distraction
- Avoid the use of physical restraints

Sexually Inappropriate Behavior??

- 4-6% in dementia
- Consider etiology:
 - Uncomfortable clothing
 - Need to toilet
 - UTI/Rash
 - Soiled
- May not be sexually related

Sexually Inappropriate Behavior

- If found undressed calmly bring a robe or blanket
- Use a matter of fact approach
- If found masturbating:
 - Do not react with upset or ridicule
 - Gently lead to a private place
 - You may (or may not) wish to distract with a tactile object

Sexually Inappropriate Behavior

- Verbal requests for sex:
 - If caused by dementia usually caused by deterioration of the frontal lobe (which regulates socially appropriate behavior and impulse control). Not very amenable to change in the later stages of dementia. Staff can firmly say “no”, try distraction, or other techniques depending on level of cognitive impairment, premorbid personality and staffs’ own comfort.

Sexually Inappropriate Behavior

- Staff response/attitudes are often a focus of treatment

Review

- Dementia
- BPSD
- Assessment of Challenging Behaviors
- ABCs of Challenging Behaviors
- Wandering/Repetitive Questions/Screaming/Verbal&Physical Aggression/Sexually Inappropriate Behavior

Review

- Our understanding of cognitive impairment is vital to the care that we give to patients and their families affected by these illnesses.
- Our understanding of the person behind the illness makes understanding their particular presentation and their “problem behaviors” much easier to understand and work with.

Review

- Some problems are really very simple but become incredibly complicated by systems issues, policies that do not take into account that dementia is a 24hr/day condition and lack of communication.
- Get to know the people you care for, their health needs, their support systems.
- Advocate



ure. The Struldbrugers.

Top Ten Problems Amenable (Maybe!) to Medications

- Anxiety, restlessness
- Sadness, crying, insomnia
- Withdrawn, apathetic behavior
- Regressed behavior
- Verbal aggression
- Physical aggression
- Elation, pressured speech, hyperactivity
- Delusions, paranoia
- Hallucinations
- Sexually inappropriate behavior*

General Approaches to Pharmacotherapy

- Employ *non-pharmacologic* principles
- Develop psycho-behavioral metaphor

Psycho-behavioral Metaphors

- “like a depression” - antidepressants
- “as if mania” - mood stabilizers
- “like an anxiety disorder” - anxiolytics, antidepressants
- “could be psychosis” - antipsychotics
- “I have no idea!” - series of empirical trials of various meds but traditionally antipsychotics

General Approaches to Pharmacotherapy

- Initiate appropriate treatment
- Start low, go slow
- Increase dose until benefit or toxicity
- Reevaluate and taper as necessary

Pharmacotherapy in BPSD

Drug

Target Symptom

Antipsychotics

psychosis, agitation, sleep
wake cycle

SSRIs

depression, dep-agitation,
lability, anxiety

Trazodone

sleep wake cycle, agitation,
anxiety

Pharmacotherapy in BPSD

Benzodiazepines

anxiety, agitation, sleep disturbance

Mood stabilizers

agitation, manic like behavior, sleep wake cycle?

Cholinesterase inhibitors

psychotic symptoms, agitation

Memantine

agitation

BPSSD-Antipsychotics

- Typical vs atypical?
 - Atypical first line
 - Simple dosing schedule
 - Less EPSE
 - Less tardive dyskinesia
 - Sedation
 - Oral, liquid, parenteral, rapid dissolve wafer
- Ongoing debate about safety
 - Stroke

Typical Antipsychotics

- What is the current practice?
- Efficacy is superior to placebo for BPSD but with modest effect
- No clear differences in efficacy between individual drugs
- Toxicity / side effects limit use

Typical Antipsychotics

- Side effects in >80% of patients
 - EPSE
 - Gait disturbance, bradykinesia, drooling, akathisia
 - Anticholinergic
 - Hypotension / conduction disturbances
 - Sedation
 - Tardive dyskinesia

BPSD-Antipsychotics

Our clinical experience

- Physical aggression (not resistance)
- Psychotic symptoms
- Not as first line agents for sleep
- Caution in LBD!
 - Significant risk of EPSE and mortality

BPSD-Antidepressants

- Current practices?
- 1st line agents
 - SSRI
 - SNRI
 - Trazodone
- Caution/avoid
 - Tricyclics – anticholinergic, cardiac S/E

BPSD-Antidepressants

- Our clinical experience
 - Pathological crying
 - Apathy
 - Anxiety
 - Depression
 - Frontal (obsessive/”stuck”) behavior
 - Sexually inappropriate behavior*

BPSD-Antidepressants

- Trazodone
 - Anxiety/restlessness
 - sleep
 - Resistance to care
 - Prn – prior to care/appointments
 - Regular dosing – ongoing agitation / resistance in mod-severe dementia
 - Starting dose 25-50 mg/day
 - Titrate in 25-50 mg increments (divided)
 - Maximum dose 300 mg/day

BPSD-Benzodiazepines

- Our experience
 - Anxiety
 - Pre-procedure
 - Insomnia
 - Intense irritability
 - Long term use*
 - Palliative care

BPSD-Benzodiazepines

- Caution
 - No safe use in elderly
 - Worsening cognition
 - Falls
 - Withdrawal
- If using benzodiazepines use only 1

BPSD – Mood Stabilizers

- Options
 - Lithium
 - Valproate**
 - Carbamazepine
- Our experience
 - agitation
 - Manic like behavior
 - Frontal - disinhibition

BPSD - Cholinesterase inhibitors

- Recent evidence may have beneficial effects on BPSD as well as cognition
- Target symptoms: ?apathy, hallucinations, delusions
- *Lewy Body Dementia

BPSD - Cholinesterase inhibitors

- May delay nursing home placement and improve quality of life
- Can be used in combination with other classes of medications as needed
- Discontinuation
 - Taper if possible
 - May see precipitous decline (?restart)

BPSD-Memantine

- Clinical experience?
- Indications
 - BPSD in mod-severe dementia
 - +/- cholinesterase inhibitor
- Dosing
 - Starting dose 5 mg AM
 - Titrate in 5 mg increments to 10 mg BID
- Currently nonformulary
 - Cost \$200/month

Conclusions

- Mood and behavioral symptoms in dementia:
 - are common
 - are identifiable
 - are treatable
 - often respond to nonpharmacological strategies as a first line option

Conclusions

- Mood and behavioral symptoms in dementia:
 - Cause significant caregiver burden
 - Lead to nursing home placement
 - Increase cost of care directly and indirectly

Conclusions –Pharmacological Treatment

- Use psycho-behavioral metaphors
 - If it looks like...
- Treatment principles
 - Reasonable drug choice
 - Reasonable dose (titration)
 - Reasonable duration

Questions?

