



Steps To Managing Difficult Behavior In People With Dementia

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Both rising life-expectancy and dementia prevalence increase the likelihood of agitation and the accompanying behavioral and psychological symptoms of dementia (BPSD). Unfortunately, such behaviors result in an everyday struggle for many victims and their caregivers. Agitation has been defined as any verbal, vocal, or motor activity which is not judged by an outside observer to result directly from the needs or confusion of the agitated individual.¹ In other words, the cause of the behavior is not readily apparent.

Many clinicians manage problem behaviors by trial and error. But a systematic approach with consistent behavior documentation and sequence to a series of approaches can help establish which factors contribute to the agitation, and how the behaviors respond to each intervention. In general, we recommend a consistent approach to assessment, followed by non-pharmacologic and pharmacologic interventions, and a monitoring strategy.

ASSESSMENT

Because of the complex nature of agitation and BPSD, patients should be thoroughly assessed at the onset of a new behavior. Divide the behaviors into physically aggressive, physically nonaggressive, verbally aggressive, verbally nonaggressive, or a combination of types.¹

The documentation should include both the type of agitation and other characteristics. For example, document the specific behavior (etc., hitting, spitting, crying, etc), the frequency and timing of the behaviors, changes in routine or environment, onset and predominant pattern, as well as the con-

sequences of the behaviors. The day-to-day caregivers will likely have valuable insights.

Exclude delirium as the cause for the behavior; seniors with multiple medical problems are at high risk for delirium. Especially consider dehydration, infection, severe constipation, medication side effects, head trauma, and pain.

NON-MEDICATION TREATMENT

Caregivers and health care providers should always attempt non-medication interventions, a potentially very effective strategy often arising from simple ideas. Use the behavior assessment to come up with several strategies. (Table 1).

A pleasant and consistent demeanor provides an important basic daily approach to caregiver and patient interaction. Even body language—absent inflammatory words—of a frustrated or irritated caregiver can inadvertently anger a patient. Arguing with or correcting a patient with dementia usually does not support other strategies that improve challenging behaviors. Educating caregivers can reduce their feelings of burden and depression, and improve quality of life for caregiver and patient.²

DETERMINE IF MEDICATIONS ARE APPROPRIATE

Avoid adding medications to manage behaviors if the target symptoms do not cause harm or are tolerable. However, when the best attempts at non-medication management fail, a pharmacologic approach may be warranted. No medications are FDA-approved for treating behavioral symptoms associated with dementia.

Table 1. Possible non-medication interventions for difficult behaviors

Behavior	Possible reason for behavior	Possible nonmedication approach
Resisting help with bathing, grooming, or dressing	Task is too difficult or overwhelming	Break task into small steps, limiting choices to 1 or 2. Demonstrate the step; caregiver could reassure, distract with music or conversation
Incontinence	Difficulty undressing Forgets or can't express the need	Simplify clothing such as elastic waste bands Schedule toileting
Wandering	Restlessness, boredom	Provide personally meaningful activity consistent with patient's abilities (e.g., folding clothes, craft items, puzzles, cooking), provide opportunity for exercise (schedule routine walks)
Inappropriate sexual behavior	Need for attention, affection	Increase or meet basic need for touch and warmth, model appropriate touch; offer soothing object (stuffed animals); pet therapy; react calmly and firmly but do not confront

Several classes of medications comprise the largest body of evidence in the treatment of BPSD: antipsychotics, antidepressants, anxiolytics, and mood stabilizing agents.

ANTIPSYCHOTICS

Both typical and atypical antipsychotics have been systematically studied for treatment of BPSD. They have been tested for psychotic behaviors, or when a behavior is dangerous to the patient or others, or interferes with the patient's ability to receive care. Efficacy with antipsychotics is modest in rare trials and non-existent in most. Both atypical and typical antipsychotics carry the FDA black box warning about the increased risk of death^{3, 4}.

The FDA also requires a warning for atypical antipsychotics disclosing the potential risk for obesity, diabetes, and dyslipidemia associated with their use, although this is not truly a class effect and applies primarily to olanzapine and clozapine. The American Diabetes Association, the **American Psychiatric Association (APA)**, and others published a consensus statement in 2005 recommending selected monitoring for those receiving atypical agents. Factors to monitor include weight, waist circumference, blood pressure, and glucose. All antipsychotics excepting quetiapine and clozapine also carry the risk of movement disorders. In the elderly these are predominantly parkinsonism and to a lesser extent akathisia. Increased parkinsonism leads to increased risk of falls and wheelchair restriction so routine assessment particularly focused on gait must be performed. Although there is a risk of tardive syndromes, these are of much lesser concern.

ANTIDEPRESSANTS

Some evidence supports the benefit of antidepressants for BPSD. A **selective serotonin or serotonin-norepinephrine reuptake inhibitor (SSRI or SSNRI)** is a reasonable choice for demented individuals with behavioral and depressive symptoms. SSRIs may also help with anxiety symptoms. Owing to the adverse effect on cognitive function, tricyclic antidepressants are not recommended.

ANXIOLYTICS

Anxiolytics have little supporting evidence for their use for BPSD. Safety is a major concern, primarily with benzodiazepines. Major side effects include psychomotor impairment, disinhibition, drowsiness (contributing to falls), impaired cognitive function, and physical and psychological dependence. Discontinuing these agents may take weeks to months due to withdrawal phenomena. Anxiolytic use should be short-term and low dose, and patients should be monitored carefully for side effects.

MOOD STABILIZERS

A broad range of medications with mood stabilizing properties has been studied for BPSD. The most evidence is with carbamazepine and divalproex. Efficacy is modest, at best, and side effects are a concern. In their most recent prac-

tice guideline of the treatment of dementia, the APA states the evidence to recommend their use is insufficient.⁵

The evidence for the use of other medications in the treatment of BPSD is sparse or inconclusive. Cholinesterase inhibitors may reduce behavioral symptoms in individuals with dementia, although findings have been inconsistent across trials.

For all medications, start with low doses and titrate to the lowest effective tolerated dose. Regardless of medication choice, patients should be monitored carefully for side effects.

MONITORING THERAPY

Once medication is chosen for managing behavior, monitoring the response to determine effectiveness and assess for side effects. Consider the following:

1. Is it the right medication and dose?
2. Has the treatment trial been long enough?
3. Have all underlying medical contributors been adequately evaluated and treated?
4. Have the target behaviors been monitored and documented appropriately for frequency and intensity to allow an accurate followup assessment?

If the patient fails to respond sufficiently after an adequate trial, consider changing the approach. If a medication was used, decide if it was helpful at all or not and whether it is worth continuing, keeping in mind that the more psychoactive medications used the greater the chance of adverse effects. Generally the drug should be stopped and another tried. Change the dose, the medication, or add a medication for additive activity.

Dementia patients rarely need BPSD medications indefinitely. The **Center for Medicaid and Medicare Services (CMS)** directs nursing facilities to attempt a gradual dose reduction at specified intervals. (Table 2)

While not a requirement, this guidance provides a reasonable approach for ongoing BPSD management in outpatients, too.

In summary, behaviors associated with dementia challenge

Table 2. When to attempt dose reduction/tapering of psychoactive medications

Agent/Class	Gradual dose reduction interval (for therapy used to manage behavior, stabilize mood, or treat a psychiatric disorder)
<i>Sedatives/hypnotics</i> (includes benzodiazepines)	Approximately every 3 months
Antipsychotics	In the first year, twice in two separate quarters with at least one month between attempts. After the first year, at least once per year
Psychopharmacologic medications (depending on indication, anticonvulsants and antidepressants)	In the first year, twice in two separate quarters with at least one month between attempts After the first year, at least once per year

all parties. However, with an open discussion among caregivers and a systematic method of evaluation and treatment, effective management can be achieved.

SUGGESTED READING

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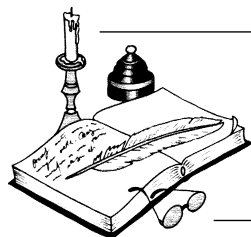
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Physician's Lexicon

The Fruitful Words of Obstetrics

Each clinical discipline in medicine possesses its distinctive history, cultural milieu and terminology. Obstetrics is no different with its abundance of words pertaining to pregnancy and childbirth: terms such as gravid, gestating, parturient, fecund and pregnant.

Gravid is derived from the Latin *gravidus* meaning heavy (with child). Cognate words, such as gravity, gravitas and grave emphasize the weightiness while ignoring its obstetrical meaning. Isaac Newton coined the verb "gravitate," in the sense of moving toward something, to describe his theory of gravity, while *gravy* is an Old English word that is ultimately traced to the Latin, *granum* [grains].

The Latin word, *parere*, meaning producing or bearing, appears in obstetrical parous, parity and viviparous [producing living young; see also words such as vivid and vivisection.] Parity, from the Latin, *paritas* meaning equal, generates a word spelled the same as the obstetrical 'parity' but with a different meaning of equality (as in the phrase 'military parity.')

Parturient, meaning to be in labor, about to deliver, descends from the Latin, *parturire*, (literally, to wish to bring forth) and ultimately from *paere*, to bring forth. Cognate words include post-partum, parity, multiparous, oviparous, puerperal, parent and even repertory (*reparare*).

Labor, meaning to toil, to experience hardship, to work, is derived from the Latin, *labare*, meaning to totter, to slip out. Derivative words include laboratory, belabor, elaborate and collaboration.

Obstetrician, is from the Latin, *obstetricus*, literally meaning, 'she who stands before', from the Latin prefix, *ob*- [before] and *stare* [to stand]. That is, a midwife.

Midwife in an Old German term literally meaning 'with woman'; the midprefix is equivalent to the German, *mit*, meaning with.

Fecundity is from the Latin, *fecundus*, meaning fruitful, fertile; literally, "that which is produced." And fertile derives from the Latin, *fertilis* and ultimately from *ferre*, to carry to bear, to produce.

— STANLEY M. ARONSON, MD