Dementia-Related Behaviors

COMMON QUESTIONS

- What are the behavioral and psychological symptoms of Alzheimer's disease and other dementias?
- What interventions and treatments are recommended for dementia-related behaviors?
- Are antipsychotic medications an acceptable therapy for the treatment of dementia-related behaviors?

BACKGROUND

Individuals living with dementia may experience behavioral and psychotic symptoms during the course of the disease due to the alteration in processing, integrating and retrieving new information. Studies have found that more than 90 percent of people with dementia develop at least one dementia-related behavior, and a significant percentage of these individuals have serious clinical implications.

Depression, hallucinations, delusions, aggression, agitation, wandering and "sundowning" are hallmark behavioral and psychotic symptoms of dementia, which commonly manifest in the moderate- to- severe stages of dementia. These symptoms cause considerable caregiver stress, and may lead to other medical complications and earlier institutional placement in long-term care facilities.

Given the severity and frequency of these symptoms and the lack of a treatment for dementia-related behaviors approved by the Food and Drug Administration (FDA), many classes of drugs (antipsychotics, antidepressants, anticonvulsants) are utilized off-label to treat these distressing features of dementia. Of these medications, antipsychotics have raised particular concern due to potential serious side effects in persons with dementia.

The FDA has weighed in on the use of atypical (second generation) antipsychotics in the treatment of dementia-related behaviors and found that using them in elderly persons with dementia was associated with increased mortality. This was based on evidence of 17 placebo-controlled trials over a 6-to-12-week period. While the medications showed significant benefit in aggression over 12 weeks, there was a 1.6-1.7 fold increased risk for mortality in the antipsychotic versus the placebo group. The sources of mortality were variable in studies, but cardiovascular and infectious causes predominated. The FDA went on to state that first generation antipsychotics also have an equivalent mortality risk.

Given the documented evidence of mortality risk and side effects such as abnormal motor function and strokes with antipsychotics, prescribing this class of drugs for the elderly with dementia has dramatically declined. However, there are instances where dementia-related behaviors pose a greater risk to individuals and families living with dementia than antipsychotic medications. For example, physically aggressive behavior can create unsafe

situations for both the person with dementia and caregivers. In these instances, psychotropic medications may need to be considered because failing to address the behavior may cause greater harm.

ASSOCIATION POSITION

Psycho-social interventions (non-pharmacologic approaches) should be tried as a first-line alternative to pharmacologic therapy for the treatment of dementia-related behaviors. Unfortunately, large population-based trials rigorously supporting the evidence of benefit for non-pharmacological therapies are presently lacking. However, there is emerging evidence to support the benefit of non-pharmacologic therapies. These therapies include validation therapy, reminiscence and other personalized psychosocial interventions.

Psychotropic medications (antipsychotics, antidepressants, anticonvulsants and others) may need to be considered when the dementia-related behavior has not responded to the non-pharmacologic approaches and is causing physical or emotional harm to the person with dementia or the caregivers. An assessment, including the presenting symptoms as well as the underlying causes of the symptoms, should be completed. Physical conditions such as pain, urinary tract infections, and constipation and medication side effects can cause or exacerbate dementia-related behaviors. These should be ruled out and treated prior to prescribing psychotropic medications.

Physical restraint therapies should be avoided in treatment of dementia-related behaviors. This includes physical or mechanical devices which confine or restrict physical activity, and should be used only in extreme situations in order to protect the person with dementia and/or others from harm. This can include railings on beds, belts on chairs, wheelchair trays, wrist and waist restraints, vest restraints or tied sheets and long-term antipsychotics. The use of restraints is highly correlated with falls, incontinence and skin breakdown. In addition, restraints contribute to emotional distress including an assault on personal integrity and freedom of movement.

Use of locks on doors to secure safe areas or disguising doors or door knobs can be helpful in maintaining safety. However, they should not be used to lock people in a space by themselves.

When using antipsychotics or other medications for the treatment of dementia-related behaviors, recommendations include ongoing and regular assessment of the need for the medication, close monitoring for side effects, appropriate dosing for elderly patients and periodic attempts at dose reduction or discontinuation.

The Association recommends training and education for both professional and family caregivers on psychosocial interventions, which may include direction to:

- Engage in routine physical activity to potentially reduce irritability and physically aggressive behavior.
- Separate the person from what seems to be upsetting him or her.

- Assess for the presence of pain, constipation or another physical problem.
- Review medications, especially new medications.
- Avoid disagreeing; respect the person's thoughts even if incorrect.
- Maintain eye contact — get to their height level and allow space.
- Speak slowly and calmly in a normal tone of voice. The person may not understand the words spoken, but he or she may pick up the tone of the voice behind the words and respond to that.
- Avoid point finger-pointing, scolding or threatening.
- Redirect the person to participate in an enjoyable activity or offer comfort food he or she may recognize and like.
- Identify if you seem to be the cause of the problem, and leave the room for a while if the person is safe.
- Validate that the person seems to be upset over something.
- Reassure the person that you want to help and, when appropriate, that you love him or her.
- Avoid asking the person to do what appears to trigger an agitated or aggressive response.

In making the decision to utilize antipsychotic therapy the following should be considered:

- Identify and remove triggers for the dementia-related behaviors: pain, under/over stimulation, disruption of routine, infection, change in caregiver, etc.
- Initiate non-pharmacologic alternatives as first-line therapy for control of behaviors.
- Assess severity and consequences of dementia-related behaviors. Less severe behaviors with limited consequences of harm to individual or caregiver (such as delusional thinking or hallucinations that are not troubling to the individual) are appropriate for non-pharmacologic therapy, not antipsychotic therapy. However, more severe or "high-risk" behaviors such as frightening hallucinations, delusions or hitting may require addition of antipsychotic trial.
- Accept that this is a short-term intervention that must be regularly reevaluated with your health care professional to determine the appropriate time of cessation.

Alzheimer's Association National Board of Directors, Approved October, 2015

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