A Proactive Approach to Managing Difficult Behaviors

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Objectives

- Understand the causes of difficult behaviors common in dementia syndromes
- Underscore the importance of caregiver support, validation, and training
- Discuss approaches to preventing and managing difficult behaviors
- Define delirium as a separate but often overlapping syndrome
- Review risks associated with hospitalization and ED visits in dementia


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Difficult Behaviors in Dementia

- Restlessness
- Anxiety
- Irritability
- Anger outbursts
- Verbal and physical aggression
- Resistance to care
- Hoarding
- Rummaging
- Inappropriate sexual behavior
- Delusions and hallucinations
- Repetitive vocalizations

Why?

- Verbal communication impaired
- Behavior IS the communication
- Holistic approach

PLST (Progressively Lowered Stress Threshold)

- Increasing inability to interpret and respond to environmental stimuli
- Less able to normalize behavior and reduce anxiety
- Care must be taken to minimize excess disability
  - Structured rest periods
  - Routine

Care Principles for PLST

- Offer unconditional positive regard
- Gauge behavior for early anxiety signs and step in before escalation
- Assess and modify environment for safe mobility
- Promote orientation with environmental cues
- Control external stimuli
- Honor rituals

10 Absolutes of Communicating through Alzheimer's

1. Never argue, instead agree
2. Never reason, instead divert
3. Never shame, instead distract
4. Never lecture, instead reassure
5. Never say "remember," instead reminisce
6. Never say "I told you," instead repeat/regroup
7. Never say "you can't," instead do what they can
8. Never command/demand, instead ask/model
9. Never condescend, instead encourage/praise
10. Never force, instead reinforce

alzheimer's caregiver institute™

Approaching Agitation

- Respond to the emotion, not the behavior
  - Avoid reasoning
  - Say what will comfort
- Provide appropriate nonverbal cues
- Unaddressed needs
  - Pain
  - Bowel/bladder
  - Hunger
- Do not reality orient
- DO NOT RESTRAIN

THE 5 R'S

- Remain calm
- Respond to feelings
- Reassurance
- Remove yourself
- Return later

Routines and Rituals

- Lessen uncertainty
  - Procedural or habit memory
- Individual approach
  - Hygiene
  - Mealtime
  - Household chores
- Reexamine regularly
  - Behavioral change may signify need for adjusting expectations
- Limit choice

Wandering

- Interpret the cause
  - Disorientation
  - Boredom
  - Basic unmet need
- Safe area to wander
  - Scheduled exercise
  - Childproofing
  - Photo albums
  - Post signs
- Alzheimer's Association Safe Return Program

Sundowning

- Increase in behavioral problems that begin at dusk and last into the night
- Factors that may contribute to sundowning and sleep disturbances include:
  - End-of-day exhaustion
  - Changes in circadian rhythm
  - Reactions to nonverbal cues from caregiver
  - Less external stimuli to aide orientation
  - Less need for sleep

https://www.alz.org/help-support/caregiving/stages-behaviors/sleep-issues-sundowning

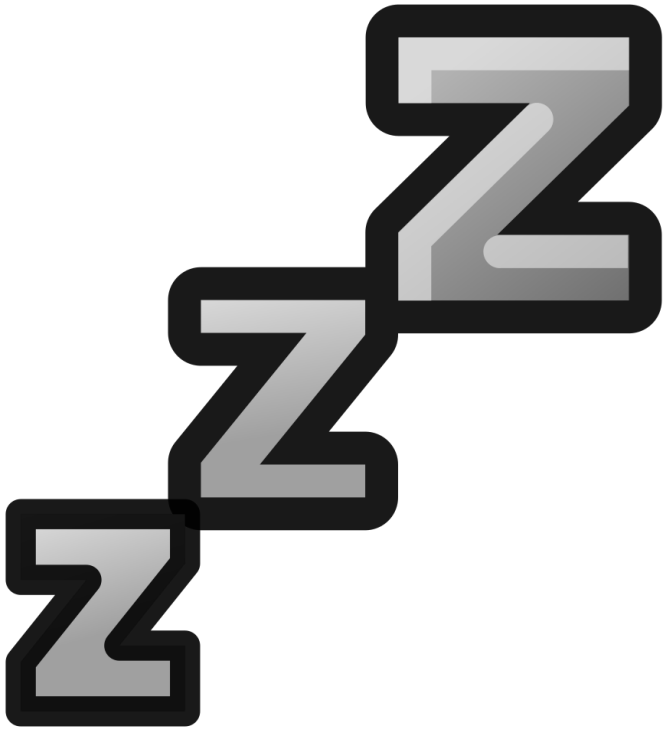
Dementia and Sleep

- Disturbed sleep/wake rhythms
- Study to examine patterns of rest/activity rhythms as they relate to dementia severity
- Results suggested a three-stage model of rest/activity rhythm changes in dementia:
  - Dementia patients have a rapid decline in rhythmicity
  - Slight return to stronger rhythms as disease progresses
  - Rhythms decline even further in late stage dementia

Gehrman P, Marler M, Martin JL, Shochat T, Corey-Bloom J, Ancoli-Israel S. The relationship between dementia severity and rest/activity circadian rhythms. Neuropsychiatr Dis Treat. 2005;1(2):155-63.

Sundowning and Sleep

- ROUTINE
- Avoid alcohol and caffeine
- Natural light
- Daytime exercise
- Limit daytime napping



Pharmacologic Treatment

- Reasons to treat:
  - Danger to self or others
  - Humane treatment when all else fails
    - Inconsolable or persistent distress
    - Inability to accept needed care
    - Significant decline in function

Antipsychotics

- Evidence on use of antipsychotics is weak and use is off-label
- RCTs show only modest efficacy with some drugs:
  - Risperidone for psychosis
  - Aripiprazole and risperidone for neuropsychiatric symptoms
  - Haloperidol with similar efficacy to atypicals
    - Use very low doses (0.5 mg)
    - Increased CV risk
  - 4 negative placebo controlled trials with quetiapine
- Antipsychotics NOT well tolerated in Parkinson's and LBD patients

AHRQ Summary of Efficacy: Atypical Antipsychotics

	Aripiprazole	Olanzapine	Quetiapine	Risperidone
Dementia-Overall	++	+	+	++
Dementia-Psychosis	+	+/-	+/-	++
Dementia-Agitation	+	++	+/-	++

Legend:

++ = Moderate evidence of efficacy

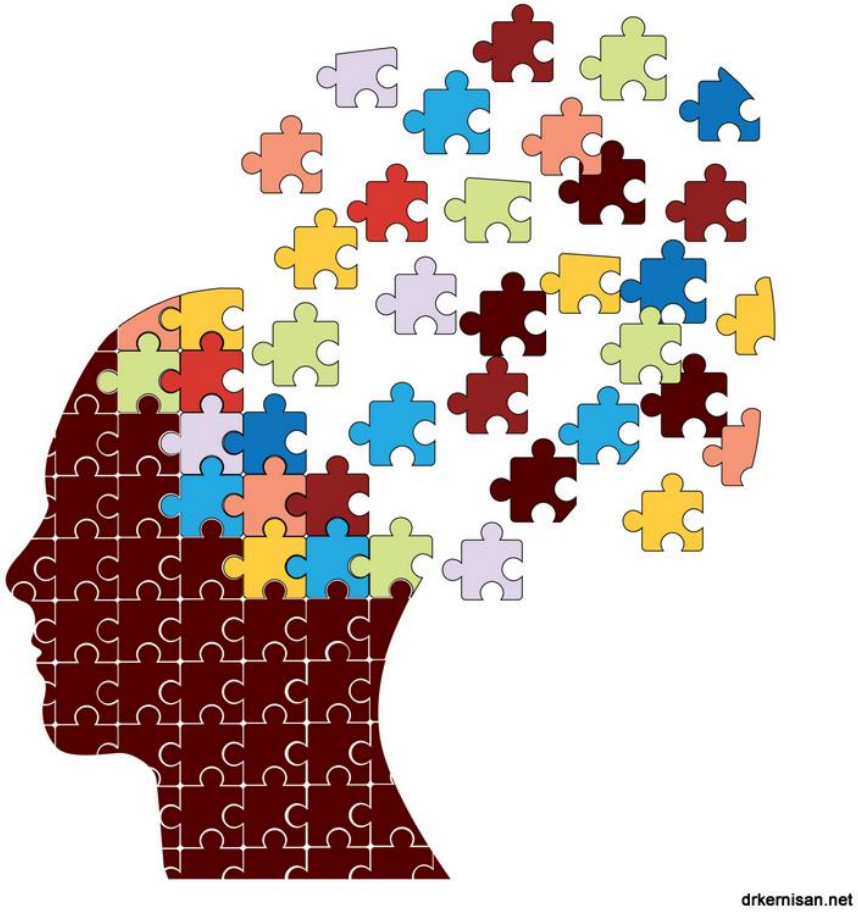
+ = Low or very low evidence of efficacy

http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=786&pageaction=displayproduct

Alternatives

- Acetylcholinesterase inhibitors (especially PD and LBD)
- Memantine
- SSRIs
- Trazodone
- Prazosin
- Melatonin

- Benzodiazepines (last resort)



DELIRIUM

DSM-V Diagnostic Criteria

- Disturbance in attention
  - Reduced awareness and ability to direct, focus, sustain, and shift attention
- Change in cognition
  - Memory deficit, disorientation, language disturbance, perceptual disturbance
- Develops over a short period and tends to fluctuate
- Provoked by other medical problem!!!

Risk factors?

- ***Pre-existing dementia***
- Medications
- Pain
- Metabolic disturbances
- Dehydration
- Infection
- Environment change
- Impaired mobility

Risks of Delirium

- Longer hospital stay (P=0.001)
- Increased association with complications (P<0.001)
- Institutionalization (P<0.001)
- 6-month mortality (P<0.001)
- Patients with dementia (N=168) had a higher delirium rate (57.7%, P<0.001) but a shorter hospital stay (P<0.001)

Mosk CA, Mus M, Vroemen JP, et al. Dementia and delirium, the outcomes in elderly hip fracture patients. Clin Interv Aging. 2017;12:421-430. Published 2017 Mar 10.

Prevention/Treatment

- Recognizing and screening patients at risk
- Avoiding/discontinuing risky medications
- Close observation for infection
- Family/friend involvement
- Decrease isolation
- Decrease sleep disturbances
- Environmental cues
- Avoiding restraints
- Avoiding “restraints”
  - Foley catheters, oxygen, IV fluids, telemetry boxes
- Vigilance for withdrawal syndromes

How to identify Deliriogenic Drugs?

It's a S.N.A.P.!!

S Sleep meds (Ambien, Lunesta)

N Narcotics (Especially Demerol)

A Anticholinergic

- Antihistamine
- Antispasmodics
  - bladder, bowel, muscle
- Antiparkinsonian

P Psych (benzodiazepines)

OR, WITHDRAWAL FROM ANY OF THE ABOVE

Delirium versus Dementia

- **Delirium**
  - Rapid onset
  - Change from baseline
  - Primary defect in attention
  - Fluctuates during the course of a day
  - Visual hallucinations common
  - Often cannot attend to MMSE or clock draw
  - Reorient frequently

- **Dementia**

  Insidious onset

  Primary defect in short term memory

  Attention often normal

  Does not dramatically fluctuate during day

  Visual hallucinations less common

  Can attend to MMSE or clock draw, but cannot perform well

  Reorienting ineffective

Avoiding Hospitalizations

Dementia in the ER

- Significantly ($p<0.001$) more likely to be admitted compared with controls
- Diagnoses
  - Syncope and collapse
  - UTI
  - Pneumonia
  - Dehydration

Natalwala A, Potluri R, Uppal H, Heun R: Reasons for Hospital Admissions in Dementia Patients in Birmingham, UK, during 2002–2007. Dement Geriatr Cogn Disord 2008;26:499-505.

Phelan EA, Borson S, Grothaus L, Balch S, Larson EB. Association of incident dementia with hospitalizations. JAMA. 2012 Jan 11;307(2):165-72.

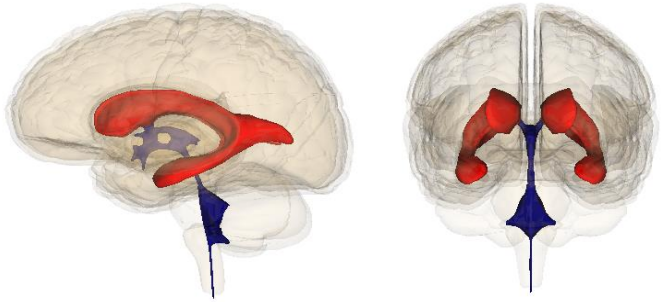
Hospitalizations and Cognition

- Multiple trials demonstrating relationship between hospitalization and cognitive decline
- Causes
  - Delirium
  - Stress
  - Medications
  - Depression

Mathews SB, Arnold SE, Epperson CN. Hospitalization and cognitive decline: Can the nature of the relationship be deciphered?. Am J Geriatr Psychiatry. 2013;22(5):465-80.

Hospitalizations and Cognition

- Brown CH, Sharrett AR, Coresh J, et al. Association of hospitalization with long-term cognitive and brain MRI changes in the ARIC cohort. *Neurology*. 2015;84(14):1443-53.
  - 14.1 years, 1226 participants
  - 53.1% hospitalized
    - Worse cognitive testing
    - Greater decline with EACH hospitalization
    - Greater decline with critical illness
  - MRI subset (n=885)
    - Hospitalization (n=392) – 57% higher odds increasing ventricular size
    - Odds increased with EACH hospitalization, critical illness, major surgery



Hospitalizations and Cognition

- 24-year surveillance period
- Subset (n=1689, mean age at MRI 76±5) of participants underwent 3-Tesla brain magnetic resonance imaging (MRI)
- 72% were hospitalized, 14% had a major infection, 4% had a critical illness during the surveillance period
- Associated with hospitalization
  - Poor white matter microstructural integrity
  - Dose-dependent
    - Smaller brain volumes
    - Lower white matter integrity
- Critical illness and major infections associated with smaller brain volumes in Alzheimer's disease signature region

Walker, K. A., Gottesman, R. F., Wu, A. , Knopman, D. S., Mosley, T. H., Alonso, A. , Kucharska-Newton, A. and Brown, C. H. (2018), Association of Hospitalization, Critical Illness, and Infection with Brain Structure in Older Adults. J Am Geriatr Soc, 66: 1919-1926.

Mortality Outcomes

- n = 10,014
- Any patient with CSD (cognitive spectrum disorder)
  - Dementia, delirium, abnormal cognitive testing
- LOS 25.0 vs. 11.8 days
  - Delirium superimposed on dementia had the longest LOS
- 30-day mortality 13.6% vs. 9.0%
- 1-year mortality 40.0% vs. 26.0%
  - People with dementia had worst mortality at 1 year
- 1-year death or readmission 62.4% vs. 51.5% (all $P < 0.01$)

Reynish EL, Hapca SM, De Souza N, Cvoro V, Donnan PT, Guthrie B. Epidemiology and outcomes of people with dementia, delirium, and unspecified cognitive impairment in the general hospital: prospective cohort study of 10,014 admissions. BMC Med. 2017;15(1):140.

Resources for help

- Alzheimer's Association www.alz.org
  - REACH program
  - Greater Dallas and North Central Texas (FTW) chapters
- Aging and Disability Resource Center
  - www.tarrantcountyadrc.org
  - www.connecttocaredallas.org
- 211
- VA resources
  - Community Living Center
- Adult day care
- Home aide services