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Challenging Behaviors

COMMON QUESTIONS

- Are antipsychotic medications an acceptable therapy for the treatment of behavioral and psychotic symptoms of dementia (BPSD)?

- Do non-pharmacologic alternatives to antipsychotics help in the treatment of BPSD?

BACKGROUND

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

Depression, hallucinations, delusions, aggression, agitation, wandering and "sundowning" are hallmark behavioral and psychotic symptoms of dementia, commonly manifested in moderate- to-severe stages of disease. These symptoms cause considerable caregiver stress, and frustration is often the breaking point prior to institutionalization in long-term care facilities. Many of these (BPSD) are also the impetus to falls, weight loss, infection and incontinence in individuals with dementia.

Given the severity and frequency of these symptoms and lack of Food Drug Administration (FDA) approved drug treatment of BPSD, many classes of drugs (antipsychotics, antidepressants, anticonvulsants) have been utilized off-label to treat these distressing features of dementia. No drug class has been utilized as often for BPSD, and shown such benefit in short-term use, as antipsychotic drugs.

The FDA weighed in on the use of atypical (second generation) antipsychotics in the treatment of BPSD and found that treatment of behavioral disorders in elderly persons with dementia by antipsychotic medications was associated with increased mortality. This was based on evidence of 17 placebo-controlled trials over a 6-to-12-week period showing significant benefit in aggression over 12 weeks; however, there was a 1.6-1.7 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 have equivalent mortality risk.

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Given the documented evidence of mortality risk and side effects such as abnormal motor function events and strokes with antipsychotics, the prescribing of this class of drugs for elderly with dementia has dramatically declined. However, there are instances where BPSD pose a greater risk to individuals and families living with dementia than antipsychotic medications. This is especially true in cases of individuals with recurrent behaviors that pose a threat to life, progressive decline in nutrition and mobility related to BPSD and severe-stage dementia with terminal delirium. In these instances the greater harm may result from lack of aggressive control of behaviors with antipsychotic therapy.

ASSOCIATION POSITION

Non-pharmacologic approaches should be tried as a first-line alternative to pharmacologic therapy for the treatment of BPSD. Large population-based trials rigorously supporting the evidence of benefit for non-pharmacological therapies are presently lacking. While evidence may be lacking, there are studies that meet scientific inclusion and there is anecdotal evidence to support the benefit of non-pharmacologic therapies for some individuals. Such therapies could include validation therapy and aromatherapies.

Restraint therapies should be avoided in treatment of BPSD. This includes physical or mechanical devices which confine or restrict the physical activity of individuals with dementia and should be used only in extreme situations in order to protect the person 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 pressure ulcerations. 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 other deterrents such as disguising doors or door knobs can be helpful in maintaining safety but should not be used to lock persons in a space by themselves.

The Association recommends training and education for both professional and family caregivers on psychosocial interventions that might include:

- Routine activity.
- Separate the person from what seems to be upsetting him or her.
- Assess for the presence of pain, constipation or other physical problem.
- Review medications, especially new medications
- Travel with them to where they are in time.
- Don't disagree; respect the person's thoughts even if incorrect.

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- Physical interaction: 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.

- If you appear to be the cause of the problem, leave the room for a while.

- Validate that the person seems to be upset over something. Reassure the person that you want to help and 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 BPSD: 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 BPSD. Less-severe behaviors with limited consequences of harm to individual or caregiver 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.

- Determine overall risk to self or others of BPSD, and discuss with doctor the risks and benefits with and without antipsychotics. Some behaviors may be so frequent and escalating that they result in harm to the person with dementia and caregiver that will in essence limit the life-expectancy and or quality of life of the person with Alzheimer's disease.

- Accept that this is a short-term intervention that must be regularly re-evaluated with your health care professional for appropriate time of cessation.

Behaviors & Symptoms Bibliography

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