Pharmacological and Behavioral Therapy for Mild to Moderate Dementia

James R. Hall, Ph.D., FACMPP, FICPP (Geriatrics) 
Departments of Internal Medicine and Psychiatry 
University of North Texas Health Science Center 
Fort Worth, Texas
1. Prevent breakdown of acetylcholine, a chemical messenger important for memory and learning, to increase availability of acetylcholine, which has been found to be low in brains of people with Alzheimer’s disease and other dementias.

2. Cholinesterase inhibitors do not cure AD and provide symptomatic help for deficits in memory, language, and thinking but will not stop the progression of the disease.

3. Cholinesterase inhibitors affect the rate of decline of cognitive functioning and the maintenance of ADLs to a modest degree. They differ in their side effect profiles and nature of treatment regimen. Effect on functional level lasts about one year. Issues of combination therapy and discontinuation.
Pharmacotherapy of Cognitive Decline and Behavioral Disorders

- Cholinesterase Inhibitors:
  - Donepezil (Aricept)
  - Galantamine (Razadyne)
  - Rivastigmine (Exelon)
    - Rivastigmine Transdermal Patch (Exelon Patch)
Donepezil

- Starting Dose- 5 mg once daily
- Titrate to 10 mg once daily in 4-6 weeks if well-tolerated
- Maximum Dose- 10 mg once daily
- Contraindications
  - Conduction abnormalities except right bundle-branch block
  - Unexplained syncope
- Caution with patients
  - Risk of ulcers
  - COPD
  - History of Seizures
- Side effects
  - Nausea 11%
  - Diarrhea 10%
  - Headache 10%
  - Insomnia 9% - may report vivid dreams
Galantamine

- Starting Dose – 8 mg once daily AM with food
- After 4 weeks increase to 16 mg once daily if tolerated can increase to 24 mg once daily after 4 weeks
- Maximum Dose – 24 mg once daily
- Contraindications
  - Conduction abnormalities except right bundle-branch block
  - Unexplained syncope
  - Severe hepatic or renal failure
- Caution
  - Risk of ulcers
  - COPD
  - History of Seizures
- Side Effects
  - Nausea 17%
  - Dizziness 10%
  - Headache 8%
Rivastigmine (Oral)

- Starting dose 1.5 mg twice daily AM & PM with food
- Titrate after 4 weeks if well tolerated increase to 3 mg twice daily then after 4 weeks to 4.5 twice daily then after 4 weeks to 6 mg twice daily
- Maximum Dose 6 mg twice daily
- Contraindications
  - Conduction abnormalities except right bundle-branch block
  - Unexplained syncope
  - Severe hepatic impairment
- Caution
  - Risk of ulcers
  - COPD
  - History of Seizures
  - Renal Impairment
- Side Effects
  - Nausea 37%
  - Vomiting 23%
  - Dizziness 19%
  - Diarrhea 16%
  - Headache 15%
Rivastigmine Transdermal Patch

- Starting dose- 4.6 mg once daily
- Titrate over 4 weeks to 9.5 mg daily
- Maximum dosage – 9.5 mg daily
- Contraindications – similar to oral form
- Cautions – similar to oral form
- Side Effects
  - Skin Irritation
Cochran Review Of ChEIs 2006

- Birks J. *Cholinesterase inhibitors for Alzheimer's disease*

- *Cholinesterase inhibitors (ChEIs), donepezil, galantamine and rivastigmine are efficacious for mild to moderate Alzheimer's disease*

- Alzheimer's disease is the commonest cause of dementia affecting older people, and is associated with loss of cholinergic neurons in parts of the brain. Cholinesterase inhibitors (ChEIs), donepezil, galantamine and rivastigmine, delay the breakdown of acetylcholine released into synaptic clefts and so enhance cholinergic neurotransmission.

*The three cholinesterase inhibitors are efficacious for mild to moderate Alzheimer's disease. Despite the slight variations in the mode of action of the three cholinesterase inhibitors there is no evidence of any differences between them with respect to efficacy.* The evidence from one large trial shows fewer adverse events associated with donepezil compared with rivastigmine.
Efficacy of ChEIs in Treatment of Dementia

- **Cognition**
  - *The three cholinesterase inhibitors are efficacious for mild to moderate Alzheimer's disease. Despite the slight variations in the mode of action of the three cholinesterase inhibitors there is no evidence of any differences between them with respect to efficacy.*
  - *Nature and extent of effects change as disease progresses*

- **Depression and Mood Disturbances**
  - *Some evidence of effects on depressed mood no strong evidence supporting use with anxiety*

- **Neuropsychiatric Symptoms**
  - *Evidence supporting effectiveness of ChEIs in reducing behavioral symptoms of dementia*
N-Methyl-D-Aspartate (NMDA) Receptor Antagonist

- N-Methyl-D-Aspartate (NMDA) receptor antagonist
  - Memantine (Namenda) approved for moderate to severe Alzheimer’s can be used as monotherapy or combination therapy with ChEIs
  - Efficacy - Appears to have some impact on ADLS and cognition when used alone or in combination
- Side Effects
  - Dizziness 7%
  - Constipation 6%
  - Confusion 6%
  - Headache 6%
  - Hypertension 3%
Abnormal glutamatergic activity leads to sustained low-level activation of NMDA receptors

Cognitive Deficit

Neuronal damage/loss following chronic insult
Memantine

- Starting dose – 5 mg once daily in AM
- Titrate in weekly increments of 5 mg to maintenance dose of 10 mg twice daily
- Maximum dosage – 20 mg daily
- Contraindications
  - Severe renal impairment
- Caution
  - History of cardiovascular disease
  - History of seizures
- Side Effects
  - Dizziness 7%
  - Constipation 6%
  - Confusion 6%
  - Headache
  - Hypertension 3%
Effects of Memantine on Behavior


Conclusion: At present, clinical trial evidence supports the use of memantine in only moderate-to-severe AD. Preliminary studies suggest benefit in frontotemporal dementia, alcohol dependence, post-traumatic stress disorder, headache and obesity, but rigorous clinical trials are needed to confirm these results. Available data indicate that across a range of clinical applications, memantine is a safe and well-tolerated drug.


Conclusion: Memantine may be safe and effective treatment for AD patients with agitation/aggression or psychosis who may be prone to rapid progression.


Conclusion: More effective than placebo in treatment of delusions, hallucinations, agitation/aggression and irritability /lability. The data suggest that memantine is effective in treating behavioral symptoms in moderate to severe AD.
Effectiveness of atypical antipsychotic drugs in patients with Alzheimer's disease


- RESULTS: There were no significant differences among treatments with regard to the time to the discontinuation of treatment for any reason: olanzapine (median, 8.1 weeks), quetiapine (median, 5.3 weeks), risperidone (median, 7.4 weeks), and placebo (median, 8.0 weeks) (P=0.52). The median time to the discontinuation of treatment due to a lack of efficacy favored olanzapine (22.1 weeks) and risperidone (26.7 weeks) as compared with quetiapine (9.1 weeks) and placebo (9.0 weeks) (P=0.002). The time to the discontinuation of treatment due to adverse events or tolerability favored placebo. Overall, 24% of patients who received olanzapine, 16% of patients who received quetiapine, 18% of patients who received risperidone, and 5% of patients who received placebo discontinued their assigned treatment owing to tolerability (P=0.009). No significant differences were noted among the groups with regard to improvement on the CGIC scale. Improvement was observed in 32% of patients assigned to olanzapine, 26% of patients assigned to quetiapine, 29% of patients assigned to risperidone, and 21% of patients assigned to placebo (P=0.22). CONCLUSIONS: *Adverse effects offset advantages in the efficacy of atypical antipsychotic drugs for the treatment of psychosis, aggression, or agitation in patients with Alzheimer's disease.*
Use of Antipsychotics in the Treatment of Behavioral Disorders in Dementia


"Atypical" antipsychotic drugs are widely used in patients with neurobehavioral disturbances related to dementia. Recent reports have highlighted the risks of these agents, including increased mortality, and the US Food and Drug Administration (FDA) has issued black-box warnings concerning their use. Studies of efficacy have shown only limited evidence that these drugs are more effective than placebo in controlling abnormal behaviors or improving the lives of patients with dementia and their caregivers. Recent evidence suggests that the older, "typical" antipsychotic drugs have at least as much risk as the atypical agents, and FDA warnings have been extended to these agents. In managing the behavioral disturbances of demented patients, clinicians must weigh the benefits and risks of these agents, use them only for severely disruptive behaviors, discontinue medications when ineffective, and inform families of the benefits and risks of treatment.
Meta-Analysis of Atypical Antipsychotics in Dementia


BACKGROUND: To review published reports of the usage of atypical antipsychotics for behavioural problems of dementia patients. METHODS: The electronic database Medline was searched from 1999 to 2006 with a combination of search terms including 'behavioural problems' and 'atypical antipsychotics'. RESULTS: Thirteen eligible studies were included in the overall analysis. The total number of participants was 1,683, of whom 1,015 received medication and 668 received placebo. Medications studied were risperidone, olanzapine, and quetiapine. Other studies examined other types of medications, such as typical versus atypical antipsychotics, but only data for atypical antipsychotics were included in the meta-analysis. The mean effect size for 7 placebo-controlled studies was 0.45 (95% CI = 0.16-0.74) for atypical antipsychotics, and 0.32 (95% CI = 0.10-0.53) for placebo. The mean effect size of all 13 studies included in the analysis was 0.31 (95% CI = 0.08-0.54). CONCLUSIONS: In general, effect sizes of atypical antipsychotics for behavioural problems are medium, and there are no statistically or clinically significant differences between atypical antipsychotics and placebo.
Use of Atypical Antipsychotics in the Treatment of Behavioral Disorders of Dementia


  CONCLUSIONS: Adverse effects offset advantages in the efficacy of atypical antipsychotic drugs for the treatment of psychosis, aggression, or agitation in patients with Alzheimer's disease.


  CONCLUSIONS: In general, effect sizes of atypical antipsychotics for behavioural problems are medium, and there are no statistically or clinically significant differences between atypical antipsychotics and placebo.


  Conclusions: In managing the behavioral disturbances of demented patients, clinicians must weigh the benefits and risks of these agents, use them only for severely disruptive behaviors, discontinue medications when ineffective, and inform families of the benefits and risks of treatment.
Conclusions on the Use of Antipsychotics with Dementia Patients

- Non-pharmacological approaches should be exhausted before using antipsychotic medications
- Acetylcholinesterase inhibitors and NMDA receptor antagonists may be effective in reducing behavioral disorders even relatively late in dementia
- Use of atypical antipsychotics is considered off label with geriatric patients
- Although clinically widely used with cognitive enhancing agents to reduce behavioral acting out atypical antipsychotics should be used cautiously
- Side-effects such as somnolence, confusion and increased fall risk and adverse cardiovascular events limit utility
Use of Antidepressants in the Treatment of Depression in Alzheimer’s Dementia (DiAD)

- Efficacy of Antidepressants
  - Thompson et al. (2007) metaanalysis findings based on 5 studies with 82 patients treated & 83 placebo:
    - Antidepressants superior to placebo for treatment response (OR 2.75, 95% CI 1.04-5.16) and remission of depression (OR 2.75, 95% CI 1.13-6.65)
    - No difference between groups in change in cognition or dropouts
    - NNT for one additional AD patient to respond to antidepressant therapy 5 (95% CI 3-59) and NNT for remission of depression 5 (95% CI 2024)

- Evidence Based Mental Health (2007)
  - Number of studies small
  - Depression in AD may respond to antidepressants with acceptable risks
  - For the present antidepressants should be considered early line treatments for affective symptoms in AD especially depression
  - SSRIs may have efficacy and are probably safest to use with careful monitoring
AChEIs in the Treatment of Depression in Alzheimer’s Dementia (DiAD)

- Acetylcholinesterase Inhibitors
  - Rozzini et al. (2007) in a 16 week study of clinic patients with AD and depression treated with AChEis report improved depressive symptoms as assessed by Geriatric Depression Scale independent of cognitive enhancement
  - Cummings et al. (2006) in a 20 week trial of donepezil patients with AD and “relatively” severe behavioral disorders report reduced NPI scores and reduction in mood symptoms especially depressive symptoms
  - Mosavinasab et al. (2007) in a double-blind, placebo controlled trial of fluoxetine and rivastigmine, rivastigmine alone or placebo report both fluoxetine and rivastigmine and rivastigmine alone produced reduction in depressive symptoms (Ham-D) without significant differences and fluoxetine and rivastigmine produced greatest improvement in ADLs and global functioning
  - Figiel and Sadowsky (2008) in a review report efficacy of rivastigmine in a number of behavioral disturbances including mood in a range of dementias
  - Recent descriptive review Cummings (2008) found most studies show mood symptoms and apathy most commonly responded to AChEis, irritability and agitation responded to memantine
Behavioral Approaches to DiAD

1. Increase daily enjoyment by encouraging activities based on previous interests – modifying to current level of ability
2. Initiate activities if the patient is unable
3. Modify/eliminate frustrating activities
4. Use redirection to maintain focus on pleasurable activities
5. Encourage discussion of favorite memories using photos/home movies or sentimental objects

Sleep Disorders in Dementia

- Sleep disturbances affect 25-35% of AD patients – neuronal deterioration in suprachiasmatic nucleus and nucleus of Meynert affect sleep homeostasis and sleep-wake control
- Risks for Insomnia
  - Excessive daytime sleeping
  - Reduced activity level
  - Low levels of daytime light exposure
- Common sleep disorders in AD
  - Insomnia
  - Sleep Apnea
  - Sleep Disorder Breathing
  - Nocturnal Agitation (sundowning)
Treatment of sleep disorders in AD*

- Effect of AD medications on sleep
  - NMDA antagonist
    - Effect on sleep unknown
  - ChEIs
    - Shortened REM Latency
    - Increased REM Density
    - Increased risk of insomnia with donepezil
    - Little negative effect on sleep with galantamine or rivastigimine

Treatment of Sleep Disorders in AD

- Non-pharmacological Treatment of Sleep Disorders
  - Dietary modification
  - Limiting frequency and duration of daytime napping
  - Sleep hygiene
  - Increasing light exposure during the day
  - Increasing physical and social activity
- Pharmacological Treatment of Sleep Disorders
  - Benzodiazepines and other hypnotics not recommended for long term use
  - Non-benzodiazepine hypnotics similar efficacy with fewer side effects but regular use of hypnotics is associated with increased fall and fracture risk
  - Sedating tricylic antidepressants may be useful
  - No strong support for use of melatonin
Communication processes related to stages of the disease

- Stage I- Early Stage “forgetfulness”
- Stage II- Moderate Stage “confusion”
- Stage III- Late Stage “disorientation”
- Stage IV- Terminal Stage “dependency”
General Approach to Managing All Challenging Behaviors

- Address safety needs
- Don’t argue with resident
- Keep routine consistent
- Use therapeutic and redirective touch
- Use calm reassuring voice and body language
- Use humor where appropriate
Progression of Behavioral Problems in Alzheimer’s Disease

- **Mild Stage** – problems related to memory and communication deficits may exhibit mild paranoia and confabulation
- **Moderate Stage** – problems related to orientation and behavioral disinhibition
- **Severe Stage** – problems related ADLs and neurovegetative processes
STAGE 1/EARLY STAGE
Concealing and Denying Memory Loss

- Word finding problems
- Loses train of thought
- Difficulty recalling names, places, things
- Hides things
- Exhibits withdrawal
- Impaired selective attention
- Attempts to hide losses
- Blames others to deal with loss
Behaviors to Meet Patients’ Needs in Early Stages of Dementia

<table>
<thead>
<tr>
<th>Problem</th>
<th>Behavioral Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Word Finding</td>
<td>Focus on content rather specific words, avoid over correction</td>
</tr>
<tr>
<td>Loses Thought</td>
<td>Repeat previous statement to cue patient</td>
</tr>
<tr>
<td>Difficulty Recalling</td>
<td>Use memory aids and visual cues and central location for things</td>
</tr>
<tr>
<td>Hides Things</td>
<td>Look in previous places, not hiding but forgetting</td>
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<tr>
<td>Withdrawal</td>
<td>Assess depression, increase interaction</td>
</tr>
<tr>
<td>Impaired Attention</td>
<td>Minimize distractions, simplify environment</td>
</tr>
<tr>
<td>Denial of Deficits</td>
<td>Respect denial as a coping mechanism, ensure safety</td>
</tr>
<tr>
<td>Blaming Others</td>
<td>View as coping, clarify and let go</td>
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STAGE 2/MIDDLE STAGE
CONFUSION
COMMUNICATION DIFFICULTIES

• Loses train of thought very easily
• Increased difficulty with comprehension/following directions
• Substitutes or uses wrong words
• Difficulty understanding figures of speech
• Difficulty with concentration
• Difficulty initiating conversation
• Repetition, verbal and behavioral
**Behaviors to Meet Patients’ Needs in Early Stages of Dementia**

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<tr>
<td>Loses Thoughts</td>
<td>Allow person to direct flow, give plenty of time to respond</td>
</tr>
<tr>
<td>Understanding</td>
<td>Speak slowly, directly avoid mixed communications, non-verbal cues, have patient repeat message</td>
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Behaviors to Meet Needs in Early Stages of Dementia

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<tr>
<td>Wrong Words</td>
<td>Focus on meaning not words</td>
</tr>
<tr>
<td>Figures of Speech</td>
<td>Use clear direct language</td>
</tr>
<tr>
<td>Concentration</td>
<td>Divide tasks into simple steps, single message, repeat</td>
</tr>
<tr>
<td>Initiation</td>
<td>Ask resident to talk about past experiences and interests</td>
</tr>
<tr>
<td>Repetition</td>
<td>Ignore and redirect</td>
</tr>
</tbody>
</table>
Behavior Management in the Later Stages

- As dementia progresses the ability to verbally express feelings, wants and needs becomes more impaired. These feelings, wants and needs are expressed behaviorally rather than verbally.
- The areas of the brain that control thinking, memory and organizing behavior lose their effectiveness.
Behavior Management in the Later Stages

- The ability to initiate and maintain the everyday activities of daily living declines and the demented person becomes dependent for every activity.
- The frontal lobes which control the inhibition of inappropriate behaviors lose their effectiveness.
Late Stage/Disorientation Stage

- Disoriented to time and place
- Uncertainty on how to react
- Confuses past and present
- Increased incidence of behavioral disturbances
- Greater incidence of mood disorders
- Problems recognizing close friends and family
Late Stage/Disorientation Stage

- Increased restlessness especially in the afternoon and evening
- Perceptual-motor problems
- Loss of logical thinking ability
- Increased word finding difficulties and confabulation
- Decline in ability to read, write or use numbers
Late Stage/Disorientation Stage

- Increased emotional lability
- Loss of impulse control
- Decline in self initiated ADLs
- Hallucinations and delusions more common
- Slowing of movement with increased fall risk
- Weight fluctuations
Dependency/Terminal Stage

- Can’t recognize family
- Unable to recognize self in mirror
- Remote memory impaired
- No sense of relatedness to past or present
- Apathetic and passive
- Perception distorted
- Oblivious to surroundings
Dependency/Terminal Stage

- Increased mouthing and utilization behavior
- Loss of coordination
- Increased immobility - may be unable to walk
- Unable to talk or says only a few words
- Unable to feed self
- Difficulty swallowing
- Incontinent of bowel and bladder
Common Challenging Behaviors in the Later Stages of Dementia

- Catastrophic Reactions
- Agitation
- Wandering and Sundowning
- Shadowing, Echoing and Repetition
- Screaming and Calling Out
- Inappropriate Sexual Behavior
- Aggression
- Resisting Care
Common Physical Causes of Challenging Behaviors

- Changes in brain functioning due to dementia or delirium
- Pain or physical discomfort
- Thirst or hunger
- Side effects of medication
- Visual and/or hearing problems
- Hallucinations
- Sensory impairment
Common Emotional Causes of Challenging Behaviors

- Feelings of being out of control
- Feeling overwhelmed by too many demands
- Fear and insecurity
- Emotional upset due to change in routine
- Frustration due to inability to convey needs, to remember or direct behavior
- Emotional reaction to behavior of family, staff or other residents
Common Environmental Causes of Challenging Behaviors

- Over or under stimulating environment
- Sudden noises or movements
- Lack of environmental cues for appropriate behavior
- Physically uncomfortable environment
- Inadequate lighting
The 6 R’s of Behavior Management

- **Restrict** - Try to get the person to stop- Ask, coax, persuade and insist. Be as forceful as the situation and safety demands. Restriction may make some individuals more agitated.

- **Reassess** - Try to determine the reasons for the behavior. Look at physical, emotional and environmental causes.

- **Reconsider** - Try to understand the behavior in terms of the limitations and changes caused by the dementia.
The 6 Rs of Behavior Management

- **Re-channel** - Direct the person’s energy toward other activities that are appropriate.

- **Redirect** - Use limited attention span to distract and redirect behavior

- **Reassure** - Maintain emotionally supportive safe and protective environment.
Catastrophic Reactions

A behavioral over-reaction to a situation expressed as a dramatic change in mood and behavior. This response can be exhibited as emotional projection (blaming, yelling, cursing), extreme tearfulness and sobbing, hysterical laughter, restlessness, wandering or anger and agitation. Something about the situation overwhelms the limited capacity of the brain-impaired person.
Causes of Catastrophic Reactions

- Physical Causes
  - Fatigue
  - Pain
  - Delirium
  - Perceptual Impairments
  - Medication Side-effects
  - Hallucinations or Illusions
Causes of Catastrophic Reactions

- Emotional
  - Feeling frustrated or fearful
  - Needing to do several things at once
  - Being hurried or cared for by someone who is rushed
  - Being upset by another person’s mood or behavior
  - Not being able to be understood
  - Not understanding what she is supposed to do
Causes of Catastrophic Reaction

• Environmental Causes
  • Too much going on - over stimulated
  • Too little going on - under stimulated
  • Unfamiliar environment or people
  • Sudden or unexpected movements or noises
  • Physically uncomfortable environment
Behavior Management Strategies for Catastrophic Reactions

- Break down tasks into manageable segments and give plenty of time to complete
- Use a calm, unhurried tone in interacting with person
- Avoid startling the demented person by approaching from the front and making eye contact before speaking
- Maintain a consistent routine
Behavior Management Strategies for Catastrophic Reactions

- Keep demented individuals away from high levels of noise or extremely busy times of day
- Increase or decrease ambient stimulation depending on response pattern of the individual
- Use gentle calming touch
- Distract and redirect
Agitation

- Agitation is a state of restlessness shown in increased levels of verbal or motor activity. Verbal behaviors that indicate agitation include cursing, yelling or screaming and loud abusive language. Agitated motor behaviors include rocking, pacing, wheeling back and forth in place, hitting, hand wringing or repetitive motor movements.
Causes of Agitation

- Physical Causes
  - Needing to go to the bathroom
  - Pain
  - Hunger
  - Perceptual impairments
  - Medication side-effects
  - Hallucinations
Causes of Agitation

- Emotional
  - Inability to understand task or instructions
  - Too many demands being placed on the individual
  - Insecurity due to changes in routine
  - Feelings of not being in control
  - Feelings of fear
  - Embarrassment
Causes of Agitation

- Environmental Causes
  - Too much or too little environmental stimulation
  - Unfamiliar environment
  - Sudden noises or rush of activity
  - Physically uncomfortable environment
Behavior Management Strategies for Agitation

- Behavioral approaches used to help manage Catastrophic Reactions may be useful with agitation. Key is determining cause of behavior.
- Redirection is the most useful first step.
Inappropriate Sexual Behavior

- Inappropriate sexual behavior includes verbal and physical sexual acting out directed toward family, staff or other residents; public masturbation and exposing genitals. Many behaviors related to sexual functioning such as disrobing and genital exposure are frequently due to non-sexual reasons such as being wet, needing to urinate or forgetting to dress.
Causes of Inappropriate Sexual Behavior

• Physical
  • Frontal lobe impairment
  • Need to urinate
  • Physical discomfort
Causes of Inappropriate Sexual Behavior

- Emotional
  - Increased general arousal
  - Stress
  - Responding to sexual behavior of another resident
  - Lack of awareness of socially appropriate place for behavior
Causes of Inappropriate Sexual Behavior

- Environmental
  - Temperature too hot
  - High activity level
  - Mistaken identity
Behavior Management Strategies
Inappropriate Sexual Behavior

- Identify causes of behavior
- Identify settings as opposed to behaviors that may be inappropriate and change setting
- For public disrobing look for clothes that are difficult to take off: blouses that button up the back or pants without flies that buckle at the waist
Behavior Management Strategies
Inappropriate Sexual Behavior

- Reduce overall level of stimulation in environment
- Help families cope with sexual advances by discussing nature of dementia and mistaken identity
Resisting Assistance with ADLs

- As dementia progresses into the later stages, demented individuals require increased assistance with dressing, bathing, toileting, and eating. The dementia makes it difficult for the individual to understand the reasons for engaging in the behavior, to understand instructions, to sequence behavior, and even to recognize the caregiver, leading to resistance, agitation, and aggression.
Resisting Assistance with ADLs

- The activities of bathing, dressing, toileting and eating are highly personal and private behaviors. The inability to carry out or control these behaviors is threatening to the person’s sense of self and frequently produces agitation. The need to maintain a sense of worth, privacy and dignity must be a central consideration when helping a demented individual with these activities.
Resisting Assistance with Dressing

- Physical causes
  - Inability to recognize body parts
  - Left/Right confusion
  - Visual, motor and tactile impairments
- Emotional causes
  - Embarrassment over inability to dress or dressing in front of others
  - Fear and mistrust
  - Inability to follow instructions and sequence
Resisting Assistance with Dressing

- Emotional Causes
  - Lack of privacy
  - Feeling rushed
  - Lack of energy or motivation to dress

- Environmental Causes
  - Ambient temperature too hot or too cold
  - Poor lighting
  - Over stimulation
Resisting Assistance with Bathing

- Physical Causes
  - Loss of ability to sense and perceive hot and cold
  - Visual impairments especially depth perception
- Emotional Causes
  - Fear of activity, falling, being vulnerable, water or caregiver
  - Inability to understand task or sequence
  - Increased anxiety about bathing or waiting
Resisting Assistance with Bathing

• Emotional Causes
  • Embarrassment over not being able to bath self or having someone else present when the patient bathes
  • Feeling rushed
  • Being frightened by chair lift, whirlpool or noise of shower

• Environmental Causes
  • Ambient lighting or temperature
Behavior Management of Bathing

- Find out about the individual’s home bathing routine and try to match preferences for time of day and bath or shower
- Don’t ask if he/she wants a bath
- Have bath at time person is already changing clothes such as morning
- Keep bathing schedule and personnel consistent
- Prepare bath before getting individual