Behavioral and Psychological Symptoms of Dementia

Dementias are one of the most feared disorders of later life and the most devastating in their toll on patient suffering and dysfunction. They are associated not only with deficits in cognition and self-care but also with psychiatric and behavioral symptoms. Most patients with dementia will develop changes in behavior and personality as the disease progresses, which disrupt family, social, and institutional networks. Alois Alzheimer noted that behavioral and psychological symptoms of dementia (BPSD) are prominent manifestations of the illness, including paranoia, delusions, hallucinations, agitation, wandering, and disinhibition behaviors.

The evaluation of BPSD requires special considerations. A careful medication review is the first step. New medications, especially anticholinergic, psychoactive, and cardiovascular medications, should be evaluated. Two instruments are useful to assess the range and severity of BPSD. The Cohen–Mansfield Agitation Inventory examines 29 types of agitated behavior (pacing, verbal or physical aggression, repetitious mannerisms, screaming, and general restlessness) and takes approximately 10 to 15 minutes to administer.

The Neuropsychiatric Inventory examines 12 neuropsychiatric symptoms (delusions, hallucinations, agitation, dysphoria, anxiety, apathy, irritability, euphoria, disinhibition, aberrant motor behavior, nighttime behavior disturbances, and appetite and eating abnormalities) common in dementia. This brief semistructured interview is administered by a clinician to a caregiver for rating the severity and frequency of the behaviors.

Two characteristic precursors to wandering are restlessness and disorientation. Patients should be evaluated for an underlying precipitating cause, such as hunger, thirst, drug use (alcohol and caffeine), or an undetected infection. Patients may wander when bored, anxious, or stressed, due to an uncomfortable environment or lack of exercise. Wandering is not amenable to pharmacotherapy. Nonpharmacologic interventions are the mainstay of managing this behavior. Providing regular exercise, a safe environment, and patient identification are essential. Wandering behavior is potentially life threatening. It is estimated that 60% of the 4 million Americans with dementia will wander away at some point in their illness.

The Safe Return Program (http://www.dementiatoday.com/alzheimers-association-safe-return-program) has helped in the safe return of over 8,000 people. Patients enrolled in the program are given jewelry to wear with a toll free number that can be called if they are found wandering.

Psychotic features of dementia include hallucinations and delusions. Patients may suspect that their family members are impostors (Capgras syndrome), believe that strangers are living in their home, or fail to recognize their own reflection in a mirror. Maintaining consistency and calmness in the environment can help reduce hallucinations. Limiting violent...
movies or television that can contribute to paranoia is advised. When hallucinations or illusions do occur, reorientation is rarely helpful and can escalate agitation. Calm distraction is advised. Confusion and loss of memory can also cause patients to become suspicious, sometimes accusing caretakers of theft, betrayal, or other improper behavior. In these cases, distraction, simple answers to accusations (without argument that suspicion is unfounded), and replacement of mislaid items (eg, “stolen” wallet) are the most helpful actions in alleviating fears. Severe hallucinations may warrant antipsychotic medication. Although antipsychotic medications can be effective, they are associated with an increased risk of stroke and death in older adults and must be used carefully.1

Although inappropriate sexual behavior is reported less frequently, it has a significant and disruptive effect on the relationship between patients and caregivers. This type of behavior includes touching, fondling, disrobing, and masturbating, as well as unwanted sexual advances, such as “climbing into bed with other residents in a nursing home” or “actual intercourse attempts” and aberrant sexual behavior, such as aggression.2 Nonpharmacologic treatments for these behaviors begin with modification. Some examples may include redirecting behavior with food, drink, or conversation; educating and counseling patients; using same-sex caregivers; and having patients wear clothing that fastens in the back. When nonpharmacologic interventions are partly effective, pharmacologic agents may be an option. There is limited evidence on randomized, controlled trials of pharmacotherapy for inappropriate sexual behavior in dementia, but few data from uncontrolled trials, case series, and individual case reports suggest efficacy of antidepressants, antipsychotics, mood stabilizers, hormonal agents, cimetidine, and pindolol.2

The axioms “first do no harm” and “start low, go slow” form the cornerstone of psychopharmacologic treatment. Success will depend on accurate identification of specific syndromes. Response to pharmacologic interventions is usually modest. For second-line therapies, providers should use target symptoms to guide their treatment. The selective serotonin reuptake inhibitor antidepressants citalopram and sertraline have demonstrated the best evidence for use in reducing symptoms such as irritability, sleep disturbances, and some aggression. Trazodone may also be helpful, particularly with sleep disturbances and agitation. Benzodiazepines can be effective but must be used with caution in the elderly. Finally, atypical antipsychotics, such as risperidone and olanzapine, may be used for controlling aggression, agitation, and psychotic symptoms.1 Close monitoring must be provided and medications should be carefully titrated for effect. These drugs should be discontinued if they are not effective in controlling the targeted symptoms.

The development of BPSD is associated with a poorer prognosis, greater impairment in activities of daily living, and diminished quality of life. Early recognition and prompt treatment of behavioral disturbances will go a long way toward improving the quality of life in patients and their families and caregivers. The goal of treatment should be to detect and manage BPSD before caregiver burnout and irreversible damage to the support environment occurs. JNP

References

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