

# Behavioral and Psychological Symptoms of Dementia (BPSD)

## 1. BPSD

- a. A heterogeneous range of psychological reactions, psychiatric symptoms, and behaviors occurring in people with dementia of any etiology.
- b. Any verbal, vocal, or motor activities not judged to be clearly related to the needs of the individual or the requirements of the situation
- c. An observable phenomena (not just internal)
- d. Range of behavior:
  - i. Psychosis (delusions or hallucinations)
  - ii. Agitation/aggression
  - iii. Apathy/indifference
  - iv. Depression/dysphoria
  - v. Anxiety
  - vi. Elation/euphoria
  - vii. Disinhibition
  - viii. Irritability/lability
  - ix. Aberrant motor behavior
  - x. Insomnia
  - xi. Appetite disruption

## 2. Prevalence of BPSD

- a. Present in all types of dementia
- b. 80-90% of patients develop at least 1 distressing symptom during the course of their dementia
- c. 60% of community dwelling patients with dementia
- d. 80% of dementia patients in nursing homes

## 3. Evaluation

- a. Obtain a clear description of problem behavior, temporal onset, course, circumstances
- b. Assess ability to express basic needs (hunger, thirst, fatigue)
- c. Look for delirium – acute/rapid change (dehydration, UTI, pneumonia, angina, constipation, pain, uncontrolled DM)
- d. Look for mood disturbance (sadness, irritability, withdraw)
- e. Check med changes – always suspect the meds
- f. Ask about environmental precipitants: change in routine, roommate, caregiver, overstimulation/understimulation, other disruptive patients, family illness
- g. “Four D” Method
  - i. Define and Describe
  - ii. Decode
  - iii. Design and Implement
  - iv. Determine

4. Staff techniques
  - a. Most situations allow for an initial non-pharmacological approach to management
  - b. Communicate face to face, speak slowly & clearly
  - c. Use verbal clues
  - d. Approach slowly and deliberately (don't surprise)
  - e. Serve as a "calming force"
  - f. Humor and laughter
  - g. Know what makes the resident tick
  - h. Act as if they function at a higher level of cognition
  - i. Sensory experience: music, dance, visual contrast, fragrances, foods, tactile stimulation
  - j. Distraction, redirection
  - k. Flexibility, "go with the resident's pace"
  - l. Anticipate challenges and difficulties – they are the normal
5. Other management techniques
  - a. Tx underlying medical illness
  - b. Correct sensory deficits
  - c. Remove offending medications
  - d. Keep environment comfortable, calm, homelike
  - e. Regular daily activities and structure
  - f. Assess sleep and eating patterns
  - g. Educate and support caregiver
6. Medications in BPSD
  - a. Currently there are no FDA approved treatments for agitation and psychosis in dementia
7. Antipsychotics - Risperdal, Seroquel, Zyprexa, Haldol, Geodon, Abilify
  - a. FDA Blackbox on antipsychotics: **WARNING: INCREASED MORTALITY FOR ELDERLY PATIENTS WITH DEMENTIA RELATED PSYCHOSES. Elderly patients with dementia related psychoses are at increased risk for death compared to placebo. This drug is not approved for the treatment of dementia related psychoses.**
  - b. Meta-analysis of 17 double blind RCT's in elderly dementia patients, April 2005. Atypicals associated with a 1.6-1.7 times greater risk of mortality compared to placebo. Most deaths from cardiac or infectious etiology, in some studies – strokes. Extended to all antipsychotics in June 2008
  - c. Common side-effects of antipsychotics: extrapyramidal symptoms (akathisia, dystonia, pseudoparkinsonism, and dyskinesia), sedation, tardive dyskinesia, gait disturbances, falls, significant increase in respiratory tract & urinary tract infections & peripheral edema in patients
  - d. Haldol for agitation in dementia (2005 Cochrane review) - Haloperidol was useful in reducing *aggression*, but was associated with adverse effects. Haloperidol should not be used routinely to treat patients with agitated dementia

- e. F-tag 329 (12/06 update) During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated
8. Cholinesterase inhibitors - Aricept, Exelon, Razadyne
    - a. Studies suggest beneficial effects on psychosis, agitation, mood, apathy, and aberrant motor behaviors
    - b. In a small number of patients, these medicines may increase agitation.
  9. Benzodiazepines - Ativan, Xanax, Restoril, Librium, Valium, Klonopin
    - a. Several studies support efficacy
    - b. Main concern is high rate of adverse events in the elderly
      - i. Psychomotor Retardation -- drowsiness, poor concentration, ataxia, dysarthria, motor incoordination, diplopia, muscle weakness, vertigo and mental confusion.
      - ii. Increased rate of falls that cause hip and femur fractures
      - iii. Paradoxical Disinhibition -- Increased excitement, irritability, aggression, hostility and impulsivity
      - iv. Memory/cognitive Impairment
      - v. Depression and Emotional Blunting
    - c. Guidelines support only short-term as-needed use
    - d. If benzodiazepines are used in the elderly, **dosage should be half that recommended for adults** , and use (as for adults) should be short-term (2 weeks) only
  10. Sleeping Pills
    - a. Ambien, Sonata, Lunesta, Restoril
    - b. Don't use Tylenol PM, Benadryl, amitriptyline
  11. Antidepressants
    - a. SSRIs are best: Celexa (citalopram), Lexapro, Zoloft
    - b. avoid Prozac and Paxil
  12. Medicine Guidelines
    - a. Delay use of meds for as long as possible
    - b. If delirious and agitated – the most quickly effective med is likely Haldol
    - c. If anxiety predominates (particularly in a cognitively intact patient) – consider cautious use of a benzodiazepine. Use Ativan (lorazepam) - avoid Xanax, Valium.
    - d. If ongoing agitation, delusions, misperception of environment – consider an atypical antipsychotic. I favor Seroquel 12.5 to 25 mg.
    - e. Attending physician should follow up promptly

### 13. Specific behavior

- a. Wandering -- meds don't usually help
- b. Disinhibition -- meds don't usually help
- c. Aberrant motor behavior -- meds don't usually help
- d. Psychosis (delusions or hallucinations) -- if not bothering residents or others, don't treat. If creating emotional distress, consider an antipsychotic medication.
- e. Agitation-- seek to identify cause of agitation, redirect, feed, change staff, if anxious consider an antidepressant or benzodiazepine, as last resort consider an antipsychotic. Meds don't help general agitation (short of overall sedation)
- f. Aggression-- seek to understand what triggers the aggression, try to alter the circumstances, if based on a delusion or misperception consider an antipsychotic
- g. Apathy/indifference -- can reflect apathy of dementia, rule out other drugs as cause, consider an antidepressant
- h. Depression/dysphoria -- consider an antidepressant
- i. Anxiety -- reassure, calm, change the environment, consider an antidepressant or benzodiazepine
- j. Elation/euphoria - a little bit is good! Consider a mood stabilizer
- k. Irritability/lability -- look for cause of irritation, consider an antidepressant
- l. Insomnia - evaluate factors that prevent sleep such as a roommate, consider depression, consider Remeron,
- m. Appetite disruption - treat depression at present, make sure chewing and swallowing is okay, consider Remeron