

## Dealing with Dementia Related Behaviors

- I. Etiologies of behavioral problems
  - A. Typical behaviors (table 1)
  - B. Multiple domains typically involved
  - C. Intrinsic (table 2)
    - i. brain damage
    - ii. comorbid medical / psychiatric diseases (including sensory deficits), especially acute onset problems
    - iii. Medications (newly prescribed, neuroactive, anticholinergic, cardiac arrhythmic drugs)
    - iv. pain
    - v. physical needs
  - D. Extrinsic (table 3)
    - i. Environment – light, noise, furniture, privacy, space, equipment and supplies
    - ii. Social – activities, structure, difficulty of tasks, relation with residents, family support
    - iii. Staff – attitudes, approaches, communication skills, adequate number, education, policy and procedures
  
- II. Approaches to behavior issues
  - A. Pharmacologic
    - i. To be addressed in detail in part two of telecast
    - ii. Certain disruptive behavior may warrant medical intervention as a primary option (table 4)
      - 1. violent behavior unresponsive to other interventions
      - 2. distressing hallucination, delusions, or paranoid ideation
      - 3. abrupt worsening of behavior associated with underlying mental or acute medical condition
      - 4. depression with impaired function / rapid change
  - B. Nonpharmacologic
    - i. Multiple approaches
      - 1. none intrinsically superior
      - 2. all require systematic, team approach
    - ii. Basic approach underlying all
      - 1. Define the behavior (table 5)
        - a. What does the person do, how often, who's involved
        - b. What preceded and resulted from the behavior
        - c. What makes it better or worse
        - d. Describe over time to establish baseline
      - 2. Determine the nature and extent as a problem (table 6)
        - a. What's the scope and severity
        - b. Who is affected (other residents, staff, family)

- c. Can the problem be circumvented (decrease other's exposure to it, re-educate staff or family)
    - 3. Determine why behavior occurs (triggers) (table 7)
      - a. Can the problem be explained by situational factors?
      - b. Is it feasible to modify the situation / environment to avoid the problematic behavior?
    - 4. Design intervention (table 7)
      - a. Multidisciplinary approach, need to involve all caregivers including family
      - b. Tools can include music therapy, art therapy, pet therapy, reminiscence therapy, social activities, spiritual activities, massage and aromatherapy, among others
      - c. Establish realistic time frames and outcomes (e.g. 50% reduction in frequency within 4 weeks)
      - d. Anticipate possible complications (especially if combined with medication)
    - 5. Evaluate and redesign as needed (table 8)
      - a. Establish frequency of monitoring depending on scope and severity of behavior
      - b. Establish who will monitor
  - iii. AMDA Clinical Practice Guideline
    - 1. multidisciplinary, multi-step process promoting above process
    - 2. does not address pharmacology in detail
    - 3. can be used as a QA guide
    - 4. complemented by Delirium Clinical Practice Guideline
- C. Examples of behavior problem solving strategies (Table 9)
  - i. Basic principles
    - 1. Early intervention
    - 2. Avoid confrontation and uncontrolled excess stimulation
    - 3. Distract and redirect
    - 4. Provide dignity
  - ii. Therapeutic interventions
    - 1. Music therapy – background, individual, social
    - 2. Sensory therapy – therapeutic touch and massage, aromatherapy, cooking
    - 3. Reminiscence therapy – audio/videotapes, memory box, socialization, distraction technique
    - 4. Social therapy – cognitive and cultural appropriate crafts, current events, field trips, food oriented events
  - iii. Control mechanisms
    - 1. contextual – frequent reminders to reduce disorientation; limited benefit in moderate and severe dementia

- 2. consequential – rewards appropriate behavior, ignores / disapproves unwanted behavior
  - 3. stimulus – decrease initiating stimuli to reduce behavior, reduce stress / triggers keeps person below threshold
- III End of Life and Behaviors
- A. Behavior changes at EOL
    - i. Apraxia (immobility); Aphasia (loss of communication); Amnesia (of all memory including family), agnosia (loss of reality) worsen
    - ii. Concomitant, progressive diseases (dysphagia)
    - ii. Difficulties defining behaviors (eg aimless vocalization)
    - iii. Different goals in plan of care
      - 1. palliative often predominates
      - 2. prevention > maintenance > restorative
  - B. Changing behaviors
    - i. passive and verbal behaviors increase (depressive related?)
    - ii. Mobility behaviors diminish (wandering, environment interactive)
  - C. Intervention changes
    - i. Reminiscent, social diminish
    - ii. One on one more important (bed and wheelchair bound)
    - iv. Limited ability to interact in end stages
    - v. Meeting physical and psychological needs (negotiated risk)

#### REFERENCES:

- 1) [www.amda.com](http://www.amda.com)  
 Website of the American Medical Directors Association (AMDA), which offers a variety of educational products related to clinical and medical direction in long term care. The Dementia Clinical Practice Guidelines (CPG) offers a structured, process –based approach to dealing with dementia in the nursing home. Other CPGs relative to this CMS webcast include Delirium, Depression, and Acute Change in Condition.
- 2) [www.ipa-online.org](http://www.ipa-online.org)  
 Website of International Psychogeriatric Association, which carries a series of “Behavioral and Psychologic Symptoms of Dementia (BPSD) Educational Packs”, covering a variety of dementia related topics.
- 3) [www.alz.org](http://www.alz.org)  
 Website of the Alzheimer’s Association, which contains a library reference center offering a variety of print and video material that can be borrowed, and links to local chapters.