Assessment and Management of BPSD

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Andrew Wiens MD FRCPC
Associate Professor
Division of Geriatric Psychiatry

Debbie Warren RN CPMHNC
Geriatric Psychiatry Outreach
P.I.E.C.E.S. Lead Facilitator

Université d’Ottawa | University of Ottawa
The Components of Managing BPSD

1. Assessment: Define target symptoms, recent changes
2. Optimize medical and psychiatric conditions and improve sensory impairment:
   • Presume delirium until proven otherwise
   • Is there a psychiatric illness?
3. Nonpharmacological interventions
   • Assess and reverse aggravating factors
   • Adapt to cognitive deficits
   • Evaluate learning/behavioural causes
4. Pharmacotherapy
   • Strategies based on dementia sub-type
   • Identify neurobehavioural metaphors
   • Other options
5. Manage caregiver stress
**Behavioural and Psychological Symptoms of Dementia (BPSD)**

- Symptoms or disorders of perception, thought, affect or behaviour that are common in dementia
- May be important for prognosis
  - Increased morbidity and mortality
  - Delusions predict faster decline
  - Highly correlated with impaired activities of daily living
Tend to occur in clusters

“Apathy”
Social and emotional withdrawal

“Aggression”
Aggressive resistance
Active physical aggression
Physical threats
Verbal aggression

“Depression”
Sad appearance
Tears
Says gloomy things

“Motor Hyperactivity”
Increased walking
Aimless walking
Moving objects
Pottering
Trailing

“Psychosis”
Hallucinations
Persecutory ideas

Consistent over 24 months
Unstable over 24 months
Robust in the literature

Do not meet criteria for typical psychiatric illnesses

McShane. Int Psychogeriatr 2002; 12(Suppl): 147-54
Behavioural symptoms vary with time

- Agitation
- Diurnal rhythm
- Irritability
- Wandering
- Aggression
- Hallucinations
- Mood change
- Socially unacc.
- Paranoia
- Accusatory
- Suicidal ideation
- Depression
- Social withdrawal

May herald the onset of dementia
May emerge or change with progression of dementia

Peak Frequency (% of patients)

Months before/after diagnosis of Alzheimer’s

Jost and Grossberg, 1996
Reevaluation and implementation of new interventions may be necessary during the course of the illness.

Jost and Grossberg, 1996
More than one symptom is common

92% had at least one symptom
~50% had 4 or more symptoms

Cummings J et al. Neurology 1994; 44: 2308-14
Tend to cause several problems

- More Rapid decline
- Functional impairment
- Psychotropic treatment
- Hospital admission
- Residential placement
- Social isolation
- Economic impact
- Patient distress
- Caregiver distress
- Emotional and physical problems
- Worse Cognitive function
- Side-effects
  - Falls
  - Injuries
- Especially with
  - Psychosis
  - Wandering
  - Insomnia
  - Agitation

BPSD

Cummings J The Neuropsychiatry of Alzheimer’s Disease and Related Diseases 2003
CALM: In urgent situations, or when symptoms are severe

- **Calm** the individual
- **Assess** the environment
  - Noxious stimuli: noise, discomfort
  - Assess safety of individual, co-residents, staff
- **Limit** access to unsafe places or situations
  - Move to somewhere safe (individual or others)
- **Medicate** as necessary
  - If somewhat cooperative: Zyprexa Zydis, Risperidal M-tab, Lorazepam
  - If uncooperative: IM haloperidol, IM loxapine

Define target symptoms
Define Target Symptoms

• What are the actual behaviours?
  – When did they emerge, where do they occur, what is the frequency and timing?
  – Whom does the behaviour have an impact on:
    • The person?
    • The family/caregiver?
    • Other patients/residents?
• What other changes or stressors are occurring in that living environment or social situation
Collect Objective Data

- Objective data is **required** in order to evaluate the response to interventions:
  - ABC charting: “Video Camera” approach
  - Behaviour monitoring tools, e.g. DOS
  - CMAI
  - The Question P.I.E.C.E.S. template
# Dementia Observation System

Use corresponding numbers to record in 15 minute intervals.

1. Sleeping in Bed
2. Sleeping in Chair
3. Awake/Calm
4. Noisy
5. Restless, Pacing
6. Exit Seeking
7. Aggressive, Verbal
8. Aggressive, Physical
Cohen-Mansfield Agitation Inventory (CMAI)

Please read each of the 29 agitated behaviors and check how often each was manifested by the patient since the last visit.

= never, 2= < once/week, 3= 1-2x/week, 4= a few times/week, 5= 1-2x/day, 6= a few times/day, 7= a few times/hour

<table>
<thead>
<tr>
<th>Physical / Aggressive</th>
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</thead>
<tbody>
<tr>
<td>1. Hitting (including self)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>2. Kicking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>3. Grabbing onto people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>7</td>
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<td>4. Pushing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>5. Throwing things</td>
<td>1</td>
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<td>3</td>
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<td>6. Biting</td>
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<td>7. Scratching</td>
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<td>4</td>
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<td>8. Spitting</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<td>9. Hurt self or others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>10. Tearing things or destroying property</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>11. Making physical sexual advances</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
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<tr>
<td>12. Pace, aimless wandering</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>13. Inappropriate dress or disrobing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>14. Trying to get to a different place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>15. Intentional falling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>16. Eating/drinking inappropriate substances</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>17. Handling things inappropriately</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<td>18. Hiding things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<td>19. Hoarding things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>20. Performing rep. mannerisms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<td>21. General restlessness</td>
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<td>2</td>
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<thead>
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<tbody>
<tr>
<td>22. Screaming</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>23. Making verbal sexual advances</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>24. Cursing or verbal aggression</td>
<td>1</td>
<td>2</td>
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<tr>
<th>Verbal / Non-Aggressive</th>
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</thead>
<tbody>
<tr>
<td>25. Rep. sentences or questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>26. Strange noises (weird laughter or crying)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>27. Complaining</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>28. Negativism</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>29. Constant unwarranted request for attention or help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>
**Presume delirium until proven otherwise**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
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<tbody>
<tr>
<td>Onset</td>
<td>Sudden</td>
<td>Insidious</td>
</tr>
<tr>
<td>Course</td>
<td>Fluctuating</td>
<td>Generally stable</td>
</tr>
<tr>
<td>Duration</td>
<td>Hours to weeks</td>
<td>Months to years</td>
</tr>
<tr>
<td>Attention</td>
<td>Inattentive, distractible</td>
<td>Usually normal</td>
</tr>
<tr>
<td>Memory</td>
<td>Immediate and recent impaired</td>
<td>Recent and remote impaired</td>
</tr>
<tr>
<td>Perception</td>
<td>Hallucinations (usually visual)</td>
<td>Hallucinations not predominant</td>
</tr>
<tr>
<td>Physical illness or drug toxicity</td>
<td>Either or both present</td>
<td>Often absent, especially in Alzheimer’s disease</td>
</tr>
</tbody>
</table>

Adapted from Cummings and Benson. *Dementia: A Clinical Approach* 2nd Edition 1992 p.15
Causes of Delirium

- **Primary neurologic diseases**
  - Stroke, esp. nondominant
  - Intracranial bleeding
  - Meningitis or encephalitis
- **Intercurrent illnesses**
  - Infections
  - Iatrogenic complications
  - Severe acute illness
  - Hypoxia
  - Shock
  - Fever or hypothermia
  - Anemia
  - Dehydration
  - Poor nutritional status
  - Low serum albumin level
  - Metabolic derangements
- **Drugs**
  - Sedative hypnotics
  - Narcotics
  - Anticholinergic drugs
  - Treatment with multiple drugs
  - Alcohol or drug withdrawal
- **Surgery**
  - Orthopedic surgery
  - Cardiac surgery
  - Prolonged cardiopulmonary bypass
  - Noncardiac surgery
- **Environmental**
  - Admission to an intensive care unit
  - Use of physical restraints
  - Use of bladder catheter
  - Use of multiple procedures
  - **Pain**
  - Emotional stress
- **Prolonged sleep deprivation**

1. Acute change in mental status?
2. Disorganized thinking?
3. Altered level of consciousness?
4. Inattention/fluctuation?
5. Psychomotor agitation/retardation?
6. Perceptual disturbance?
7. Disorientation?
8. Sleep wake cycle altered?
9. Memory impairment?

Confusion Assessment Method

Most important

Least Important

Inouye, S. Ann Intern Med 1990; 941-8
Confusion Assessment Method

1. Acute onset/fluctuation?
2. Inattention?
3. Disorganized thinking?
4. Altered level of consciousness?
Is there a Psychiatric Illness?

• BPSD may be due to a long-standing, recurrent or even a new-onset psychiatric disorder
• Ask about:
  – Past psychiatric history
    • Includes history or traumatic event and/or abuse
  – Family psychiatric history
• If positive:
  – Past treatment
  – Response to treatment
  – If “safe”, use this treatment and monitor
Many behaviours unlikely to respond to medications

- Purposeless and repetitive behaviour: motor and verbal
- Resistance to care
- Sexually inappropriate behaviour
- Inappropriate dressing/undressing
- Wandering
- Exit-seeking
- Inappropriate urination/defecation
- Annoying repetitive activities (perseveration) or vocalization
- Hiding/hoarding
- Eating inedible items
- Tugging at/removal of restraints
- Pushing wheelchair bound co-residents
Assess and reverse aggravating factors: behaviour communicating an underlying need

| Sensory deprivation or deficits | May lead to perceptual distortions: Hearing aids, glasses  
Sensory Stimulation (C): **Snoezelen/multisensory stimulation (B)**, **Music/music therapy (B)**, **Aromatherapy (B)**, Massage/touch |
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<tbody>
<tr>
<td>Excessive stimulation</td>
<td>Reduced stimulation units (D): Camouflaged doors, small-groups for activities and dining, neutral colours, no TVs, radios or phones, use of quiet voices helped decrease agitation and use of restraints</td>
</tr>
<tr>
<td>Boredom</td>
<td>Structured activities and exercise (D): Recreational interventions</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Pet therapy, One-to-one interaction, Simulated interaction (D)</td>
</tr>
<tr>
<td>Quality of care</td>
<td><strong>Psychoeducation (A); Multi-session hands-on training but repeated ongoing training is necessary (B)</strong></td>
</tr>
<tr>
<td>Reducing restraints</td>
<td>Removal of restraints; restraints often worsen behaviour</td>
</tr>
<tr>
<td>Light levels</td>
<td>Bright light therapy; Associated with high contrast tablecloths, napkins, etc., increased food intake and reduced agitation</td>
</tr>
<tr>
<td>Toileting/Bathing</td>
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Adapt to cognitive deficits: mismatch between environment and ability to cope with situation

Bars show 25th to 75th %ile of patients losing independent performance.

May eventually produce a behavioural change even in the face of normal levels of stimulation.

Learning/Behavioural: mostly case studies

Behaviour Therapy (B):
- Connection made between
  - Antecedents (triggers)
  - Behaviour, and
  - Consequences (reinforcement)
- Behaviour excesses: Modify reinforcer
- Behaviour deficits: Use reinforcer

Cognitive Techniques:
- **Cognitive Stimulation (B)**
- Reality Orientation (D)
- Reminiscence (D)
- Life Review
- Validation Therapy (D)
Identify Neurobehavioural Metaphors

- **Anxiety**: restlessness, hand-wringing, pressured pacing, fidgeting, agitation
- **Sadness**: crying, anorexia, terminal insomnia, nihilism, guilt, screaming
- **Withdrawn**: apathy, quiet negativity, anorexia, sullenness, uncooperation
- **Markedly bizarre or regressed behaviour from previous standards**
- **Over-elation**
- **Overly boisterous**: verbal hostility, aggressiveness, argumentativeness
- **Delusions**: ideas of reference, paranoia, persecuted, sensory
- **Hallucinations**
Depression or Dementia?

Cognitive impairment

- Depression
  - Started before
    - Dementia with depression
  - Started suddenly after depression
    - Pseudodementia
  - No depression (no initiative)
    - Apathy
# Depression or Dementia?

<table>
<thead>
<tr>
<th>Dementia/Apathy</th>
<th>Depression</th>
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<tbody>
<tr>
<td>Insidious</td>
<td>Acute</td>
</tr>
<tr>
<td>Slow progression</td>
<td>Rapid progression</td>
</tr>
<tr>
<td>Labile mood</td>
<td>Consistently depressed, can also be irritable, unreasonable</td>
</tr>
<tr>
<td>Can enjoy things</td>
<td>Cannot enjoy things, preoccupation with somatic symptoms, pain, excessive talk of death</td>
</tr>
<tr>
<td>Cooperative, doesn’t initiate</td>
<td>Uncooperative or does not try, agitation, physical aggression, isolative behaviours, refuses to eat, slow progress in rehabilitation</td>
</tr>
<tr>
<td>Aphasia, word-finding difficulties</td>
<td>No aphasia</td>
</tr>
<tr>
<td>No history of mood disorder</td>
<td>History of Mood Disorder</td>
</tr>
</tbody>
</table>
Treatment of Depression in Dementia

• Nonpharmacologic:
  – Exercise
  – Education of caregivers on behaviour-modifying techniques
  – Degree of cognitive impairment and aphasia may limit ability to do psychotherapy

• Pharmacological
  – SSRIs:
    • Citalopram: Superior to placebo for depression and agitation
    • Sertraline: Superior to placebo for depression only
  – Other antidepressants

Psychosis: Clinical Associations

- Hallucinations (especially visual)
  - More severe cognitive impairment
  - More rapid progression
  - Impaired visual acuity, cataracts
  - Consider Lewy Body Dementia
- Delusions: no robust association
- Other possibilities
  - Misplaced objects, misidentification
  - Poor lighting, new caregivers
  - Illness, infection
  - Social Isolation
Psychosis in degenerative dementia

Cummings J The Neuropsychiatry of Alzheimer’s Disease and Related Diseases 2003
Psychosis: Management

• Resolution rate:
  – ~50% by 3 months
  – Up to 65% by one year

• Non-pharmacological
  – Social interaction: real or taped (better; esp. if family member)
  – Educate caregivers that these arise from disease
  – Ignore; frequency may ↓
  – Access to outdoors
  – Signs, cueing to decrease misidentification

• Pharmacological
  – Neuroleptics if delusions cause considerable distress?
When to consider pharmacologic treatment of BPSD

• Behavior is dangerous, distressing, disturbing, damaging to social relationships and persistent
  AND
• Has not responded to comprehensive non-pharmacologic treatment plan. Including removal of possibly offending drugs OR
• Requires emergency treatment to allow proper investigation of underlying problems
Pharmacotherapy of BPSD

- Based on dementia sub-type
- Cognitive enhancers
- Antipsychotics
- Other medications
Based on Dementia Sub-types

- **FTD**
  - Based on 2 small RCTs
  - Treatment can include
    1. Trazodone: some benefits, especially irritability
    2. Paroxetine

- **DLB**
  - Rivastigmine can decrease BPSD including hallucinations
  - Antipsychotics should generally be avoided in DLB

- **PDD**
  - Quetiapine may be less likely to exacerbate motor symptoms
  - If no response to ChEI or quetiapine, there is some support for clozapine in psychosis associated with PD
Effect of stopping Donepezil


**Behaviour**

**Caregiver distress**

NPI: Neuropsychiatric inventory  SEM: Standard error of the mean  
*: p < 0.05  ***: p < 0.0001

Weeks: 0 to 12 open label, weeks 12 to 24 donepezil  
Placebo
Donepezil for Agitation in Alzheimer’s Disease

Howard et al. NEJM 2007; 357: 1382-92
Antipsychotics: Meta-analyses in BPSD

Atypicals:
- **Agitation**: efficacy only for Risperidone and Aripiprazole
- Smaller effects: less severe dementia, outpatients, **psychosis**
- Cognitive scores worsened with all drugs
- Clinical improvement should be expected within 10-12 weeks
- If improvement isn’t seen in this interval, discontinue the medication and consider another approach

Conventionals:
- Effective in 1/3 of cases
- Improvement ~18% greater than placebo
- Type doesn’t matter
- Modest effects
- Considerable toxicity

Schneider, Dagerman, Insel *Am J Geriatr Psychiatry* 2006; 14: 191-210
CATIE-AD phase 1: Randomized phase
Clinically significant outcomes of those remaining on treatment

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<tr>
<th></th>
<th>Much or Very Much Improved</th>
<th>NNT</th>
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<tbody>
<tr>
<td>Olanzapine</td>
<td>45%</td>
<td>20</td>
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<tr>
<td>Quetiapine</td>
<td>52%</td>
<td>8</td>
</tr>
<tr>
<td>Risperidone</td>
<td>61%</td>
<td>5</td>
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<tr>
<td>Placebo</td>
<td>40%</td>
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Adapted from: Sultzer et al. Am. J. Psychiatry 2008; 7: 844-54
Risks with Antipsychotics in elderly

- **Death**
  - Atypicals: 3.5% deaths 2.5% on placebo over 10-12 wks
  - Conventional: possibly greater; Haloperidol >> loxapine

- **Cerebrovascular Adverse Events** in 26,157
  - OR 9.9 in 1st week, atypicals and conventionals
  - OR 1 by 3rd month

- **TD:** 21,835 with dementia newly started on antipsychotic in Ontario 1997-2001
  - 9790 on atypicals: 5.19 cases of TD per 100 pt-years
  - 12,045 on conventional: 5.24

- **Falls:** Meta-analysis: OR in elderly (>60 yrs): 1.71

- **Pneumonia:** In 22,944 elderly, highest in 1st week, OR: atypicals 4.5, conventionals 1.5

“Guidelines”

• Document informed consent
  – Risk/benefits
  – Consequences of not treating
• Use lowest effective dose, monitor side effects
  – ↑sedation
  – ↓BP
  – gait disturbance
• Be cautious if previous history of CVA/TIA or significant risk factors (optimize management of risk factors)
• Regularly reassess need for continued use and carefully document
• If used: try to taper/withdraw Q 6 months
  – Placebo-controlled withdrawal studies → no worsening of behaviour in most when neuroleptics are discontinued

Adapted from Rabins & Lyketsos, 2005
Other Agents in BPSD

• Anticonvulsants:
  – Carbamazepine: 1 positive and 1 negative trial. AEs include hepatotoxicity and blood dyscrasias. Minimal evidence to recommend
  – Divalproex: no benefit in 4 RCTs

• BZDP: One RCT: Lorazepam IM = Olanzapine IM > placebo; limit use to 2-3 weeks. May disinhibit

• Antidepressants
  – SSRIs:
    • Citalopram > perhenazine + placebo: depression & agitation
      – Equivalent to but fewer S/E than risperidone
    • Sertraline superior to placebo for depression only
  – Trazodone: some effect in FLD; none otherwise
Caregiver stress

Neuropsychiatric symptoms

- Burden
- Expense
- Time demands ↑ with severity
- Social isolation

Extreme fatigue & stress

- Illness & mortality
- Poor quality of life
- Emotional distress

- •40% depressed
- •Anxiety

Caregiver Support: increasing resources

**Education**

- Communication of diagnosis and its implications from first visit on
- Information by Alzheimer’s Society and other interested groups
  - First Link learning series (ASORC)
  - Local caregiving support groups
- Perceptions: labeling, attitude towards behaviour management, philosophy of nursing home

**Sources of Care and Support**

- Respite services
- Day Care Services
- Need for supports?
  - Living situation
  - Available relatives, friends
  - Paid assistance
  - In-home services: Home Care, Meals-on-wheels
  - Counselling
  - Financial resources
- Be alert for elder abuse
- Alzheimer’s Society Safely Home Registry: for wanderers
**Change your reaction to the behaviour**

- Ignore the behaviour
- Reframe the behaviour
- Educate caregivers
  - Perceptions: **labeling** - the behaviour is not the person “We can’t deal with psychiatric patients”
  - Caregiver stress: Stress Inoculation Paradigm

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Misinterpretation</th>
<th>Re-interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking repetitive question</td>
<td>They can control this but they are trying to annoy me</td>
<td>They cannot keep track of time</td>
</tr>
<tr>
<td>Accusing caregiver of stealing</td>
<td>They are paranoid and trying to embarrass me</td>
<td>This is due to memory failure</td>
</tr>
<tr>
<td>Hitting</td>
<td>They’re cruel and just want to hurt me on purpose</td>
<td>This is loss of control due to brain damage</td>
</tr>
</tbody>
</table>

**Stress Inoculation Paradigm**

- **Prepare** for the stressful event
- **Confront** and handle the stressful event
- **Coping** with feelings of being overwhelmed
- **Evaluating** the coping efforts and rewarding oneself

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*Conn et al. Practical Psychiatry in the Long-Term Care Home 3rd Ed. 2007 Hogrefe & Huber*
Challenges from home to LTC

- Many people with BPSD living together in a sometimes “challenging environment” that may be “new surroundings” every day
- Family stressed and often in crisis mode on admission
- Largely unregulated staffing environment that practices in the context of “unpredictability, variability and person threat” (Janes 2008) due to the resident’s cognitive impairment
Psychoeducation for LTCH staff

• Provincial programs:
  – Gentle Persuasive Approach for all LTCH staff
  – U-FIRST for unregulated care providers
  – P.I.E.C.E.S. Program for registered staff
• Best Friends approach
• Care models, e.g. Gentlecare, Eden alternative
• Formal and informal clinical case reviews on individual units
Opportunities

• Develop realistic, reasonable and achievable goals for persons with BPSD, their families and formal caregivers
• Participate and advocate for the development of local specialized LTCH units for those with very challenging BPSD
• Continue to promote evidence-based person-centered dementia care to staff and families
• Support front-line staff in integrating knowledge into their practice
The Components of Managing BPSD

1. Assessment: Define target symptoms, recent changes
2. Optimize medical and psychiatric conditions and improve sensory impairment:
   • Presume delirium until proven otherwise
   • Is there a psychiatric illness?
3. Nonpharmacological interventions
   • Assess and reverse aggravating factors
   • Adapt to cognitive deficits
   • Evaluate learning/behavioural causes
4. Pharmacotherapy
   • Strategies based on dementia sub-type
   • Identify neurobehavioural metaphors
   • Other options
5. Manage caregiver stress