Differentiating Behavioral and Neuropsychiatric Symptoms in Dementias

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"Good evening. You're probably all wondering why you just walked into this room."
Objectives

• Overview of behavioral & psychological/neuropsychiatric symptoms in dementia

• Discuss where they differ and overlap

• Highlight symptoms that have greater impact to person with dementia and caregivers

• Discuss treatment modalities
Differences: Behavioral vs. Neuropsychiatric Symptoms
**Neuropsychiatric symptoms** refer to underlying mental health conditions, symptoms or syndromes that often lead to disturbance in behavior.

**Behavior** is defined as the way in which a person acts in response to a particular situation or stimulus.
Neuropsychiatric Symptoms

- Delusions
- Hallucinations
- Apathy
- Anxiety
- Sleep disturbances
- Depression
Behavioral Symptoms

- Agitation
- Aggression
- Wandering
- Pacing
- Elopement
- Restlessness
- Repetitive questioning
Disinhibition
Resistance to cares
Sexually inappropriate behaviors
Hoardings/rummaging/collectioning
Anxiety

Behavioral Symptoms

Neuropsychiatric Symptoms
How do we approach?
Approach

• Neuropsychiatric symptoms may be approached in a way that looks to treat underlying mental health issue or other syndrome

• Behaviors should be approached in an investigative manner to help identify causes for a certain behavioral response
Assessment of Symptoms

- **Timing**
  - When does it occur?
  - Duration of behavior/symptom?
  - How long has this persisted or is it new?

- Where did it occur?

- Who was present?

- What was setting/environment/context?

- What was response, what works/what doesn’t?

- Any known pattern
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Common Contributing Factors (CCF)
Global sensory impairment

- Hearing loss
- Vision loss
- Neuropathy
- Taste or smell impairment

CCF: Common Contributing Factors*
Some complex behaviors associated with dementia were reduced, per caregiver reports, after patients received amplification (Palmer et al, 1998, as cited in Jorgensen, Palmer, Pratt, Erickson, & Moncrieff, 2016)

Hearing aids may reduce caregiver burden (related to repetitions, “I can’t hear you,” TV/radio/talking too loud, forgetting, auditory hallucinations) (Jorgensen, Palmer, Pratt, Erickson, & Moncrieff, 2016)

Underlying prior psychiatric comorbidity (i.e. major depressive disorder, generalized anxiety disorder) (Kales et al, 2015)
Medical Factors

- Chronic diseases: cerebral vascular accident (stroke), diabetes, COPD, CHF
- Osteoarthritis/pain
- Infection
- Medications
CCF: Caregivers

Caregiver burden:
- Burnout
- Depression
- Anxiety
- Cultural considerations

CCF: Common Contributing Factors*
Caregiver approach:
• Communication approach
• Expectations of the patient
• Misconception of purposeful intent
• Cultural considerations
CCF: Caregivers

Caregivers include:

- Spouses
- Children
- Significant other
- Family members
- Direct care workers in facilities
- Supportive home care workers

CCF: Common Contributing Factors*
CCF: Common Contributing Factors

- Environmental considerations
- Difficulty communicating or expressing underlying motives, needs, or triggers
General Strategies

- Provide caregiver education
- Enhance effective communication between caregiver and individual
- Assist caregiver in creating meaningful activities for individual
- Help caregiver to simplify tasks & establish a structured daily routine (including safety planning & modifying environment)
Employ strategies to reduce caregiver strain
Consider caregiver response to the behaviors
Consider if the behavior is a problematic or simply bothersome or draining to the caregiver
What is Apathy?

Complex neuropsychiatric syndrome characterized by lack of motivation that is not attributed to altered consciousness, cognitive impairment or emotional distress.
John is an 84 year old white male with Dementia related to Alzheimer’s disease. He resides at home with his wife who is his primary caregiver. John has a blunted emotional response, general lack of motivation and interest that is impacting ability to have him complete hygiene and participate in household activities that he is both cognitively and physically able to accomplish. John has also had declines in his level of mobility recently due to lack of motivation and interest in regular activity. John’s wife exhibits many signs of caregiver strain and reports frustration and inability to maintain composure frequently related to his passive resistance to participate in self care and other activities. In addition to the frustration, wife struggles with general understanding of cognitive and behavioral changes that occur in dementia and struggles with learning new information and incorporating behavioral strategies due to her current level of stress.
Recognizing Apathy

• Often mistaken for or co-occurring with depression
• Lack of motivation
• Diminished goal-directed behavior and cognition
• Lack of emotion
• Not associated with significant impact on cognition, however significantly associated with functional decline
• One of the most common neuropsychiatric symptoms in Dementias
• Associated with increased caregiver strain
Impact of Functional Status

- Persons with apathy are at greater risk for functional decline in IADL’s and ADL’s
  
  (Clarke, et al 2010)

- Apathy is associated with poor rehabilitation outcomes and reduced quality of life

- Associated with reduced survival after nursing home admission
  
  (Brodaty, et al 2012)
Caregiver Impact

- Caregiver burnout
- Diminished communication
- Decreased social involvement & quality of life
Treatment Modalities

- **Music intervention** (Tang et al, 2018)
- **Individually provided therapeutic activities** (Brodaty, Henry et al., 2012)
- **Pet therapy**
- **Exercise**
- **Medication intervention-stepwise intervention cholinesterase inhibitors, SSRI, Methylphenidate**
Case Study - Apathy: Recommendations

- Consider ways to lessen strain for wife to promote her being able to remain in the caregiver role. Consider supportive home care to assist with housekeeping or meals, respite options to allow wife periods of time without caregiving duties, support groups, education, and normalizing dementia related behaviors.
- Give member a purpose - Enjoys his volunteer visitor because he feels he’s helping her. Find other activities or socialization opportunities that target desire to help or have purpose and areas of interest.
- Encourage structured & stable routine, as able; helping him know what to expect may be comforting and increase participation.
- Promote positive social interactions & coping skills (will need prompts to do these activities): listening to music, reading books, looking at magazines about areas of interest, meals out with family.
- Consider cholinesterase inhibitor and assess efficacy with regards to apathy.
- Consider increase in antidepressant dosing and assess efficacy.
Sexualized Behavior

Sexual disinhibition

- Excessive or inappropriate masturbation
- Other sexual inappropriateness (verbal, touching, grabbing, illegal acts)
- Hypersexuality
Case Study: Hypersexuality

Leonard is a male 73 year old, widowed, Caucasian veteran living in CBRF setting. He has major neurocognitive disorder due to vascular dementia, as well as major depressive disorder and a trauma history related to serving (details unknown). He has sexually disinhibited behavior, he makes sexual comments towards female staff, attempts to kiss staff, and engages in compulsive masturbation during bathing. Issues began while still living at home with wife, prior to her death.
Inappropriate voiding

- Voiding in unsuitable areas: i.e. garbage cans, plants, on flooring or furniture
- Attempting to void at inappropriate times/situations: i.e. public areas with people present
Paul is an 84 year old, Cambodian male with major neurocognitive disorder due to Alzheimer’s disease residing in a CBRF setting. Emigrated from Cambodia to Thailand as refugee, then to U.S. ~40 yrs ago. Trauma history from Khmer Rouge era (soldier, refugee camp). No former education; worked as a farmer.

Primary language is Khmer; can become frustrated due to language barrier. He urinates throughout CBRF (i.e. in other residents’ rooms, on their beds & belongings, in vents); he wears pull-ups. Paul can become combative with incontinence cares. He moves furniture around the facility, walks in facility often, is restless at night, naps in the daytime. History of constipation & urinary retention.
Sexualized Behavior: Prevalence & Impact

- Social stigma
- Physical manifestation occurs more often in males vs females (De Giorgi, et al 2016)
- Caregiver burden
- Loss of housing
Sexualized Behavior: Treatment Modalities (General)

- Focus on variables that can be predicted & controlled
- Address potential understimulation
- Avoid lecturing/explaining why the behavior is inappropriate
- Guiding to more appropriate location, if safe
- Clothing that is difficult to remove independently or takes longer to remove
Sexualized Behavior: Treatment Modalities (General)

- Medication intervention - stepwise approach
- Consider medications that could be impacting
Sexual Disinhibition

• Consider who is present & adjust staff and/or residents accordingly
• Avoid overstimulating media & content (TV, radio, magazines, computer) that may be provoking
• Consider possibility of misinterpreting social cues
• Avoid use of pet-names, unnecessary touch, etc.
• If police involvement, create collaborative plan to ensure they understand dementia dx is causing these behaviors
Inappropriate Voiding

Consider possibility of misinterpreting environment due to dementia (flower pots, planters, toy and activity bins, garbage and recycling cans)

- Remove items or minimize access in their area
Case Study

Inappropriate Voiding: Recommendations

• Avoid explaining or lecturing – not his fault or choice
  ▪ Avoid appearing angry or upset
  ▪ He will not understand due to language barrier and dementia
  ▪ This may agitate him more
• Physically guiding him away from person or to more appropriate location
• Place vessel below to lessen property damage
• Use of handheld urinal
• Clothing that is harder to remove, requires assist from another person, opens in back, takes longer (i.e. overalls, multiple buttons)
• Remove items that can be misinterpreted (i.e. flower pots, planters, toy/activity bins, garbage/recycling cans)
Case Study
Inappropriate Voiding: Recommendations

• Proactive toileting and incontinence care

• Consider labeling of bathroom & toilet
  ▪ Visual cue instead of words
  ▪ Khmer language
  ▪ Review with family the types of toilets used in past

• Contrasting color of toilet vs. seat vs. floor

• Consider removal mirrors in bathroom

• PCP to address constipation and urinary retention

• Evaluation of hearing, sight
Case Study

Hypersexuality: Recommendations

- Reduce potential understimulation
- Alternative tactile stimulation
- Avoid explaining or lecturing— not his fault or choice
  - Avoid appearing angry or upset
- Assess who is present; adjust staff and/or residents accordingly
- Avoid overstimulation media that may be provoking
  - The History Channel all day (Veteran with PTSD)
- Consider possibility of misinterpreting social interactions
Case Study
Hypersexuality: Recommendations

• Clothing that is harder to remove, requires assist from another person, opens in back, takes longer (i.e. overalls, multiple buttons)

• Acknowledge person as sexual being; support privacy and healthy sexuality

• Utilize bedroom for privacy

• Address potential hygienic concerns

• Plan with police
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