

Nonpharmacologic Approaches to Behavioral & Psychological Symptoms of Dementia



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Objectives:

1. Define behavioral and psychological symptoms of dementia (BPSD).
2. Describe common behaviors and symptoms of BPSD.
3. Discuss evidence-based guidelines and effective approaches/strategies for the nonpharmacologic management of BPSD.

- Behavioral & psychological symptoms of dementia (BPSD), also known as *neuropsychiatric symptoms (NPS)*, represent a heterogeneous group of non-cognitive symptoms & behaviors occurring in individuals with dementia (Cerejeira, Lagarto, & Mukaetova-Ladinska, 2012)




- Descriptive
- Correlate strongly with the degree of functional & cognitive impairment

- A heterogeneous range of psychological reactions, psychiatric symptoms & behaviors occurring in people with dementia of any etiology (Kalapatapu & Neugroschl, 2009)
 - Disturbed thought/perception, mood symptoms, aberrant motor behaviors & inappropriate behaviors
- Inappropriate verbal, vocal, or motor activity that is not judged by an outside observer to be an obvious outcome of the needs or confusion of the individual (Livingston et al., 2005)


- **Behavioral**
 - Yelling out, pacing, wandering, resisting care, overdressing, disrobing in inappropriate areas, sleep disturbances, inappropriate sexual behaviors, agitation, shadowing, restlessness, aggression (*verbal or physical*), hitting, scratching, cursing/screaming, negative name calling, repetitive vocalization, disruptive ...
- **Psychological**
 - Depression, anxiety, psychosis (*delusions, hallucinations, misidentification*), phobias, sundowning, apathy, spiritual distress, mood swings ...

- **Activity Problems**
 - Purposeless activity
 - Wandering
 - Restlessness
 - Intrusiveness
 - Inappropriate behaviors
- **Paranoia & Delusions**
 - Suspicious
 - “People are stealing my things”
 - “They are watching me”



- **Independently associated with poor outcomes:**
 - Distress & burden among patients, caregivers, health care professionals
 - Long-term or frequent hospitalization
 - Early institutionalization
 - Rapid cognitive decline
 - Medication mismanagement 
 - Increased health care costs
 - Decreased quality of life (QOL)

Guiding Principles



- Accept present level of functioning
- Non-confrontational approach
- Respect & optimize autonomy
- Simplify the environment
- Repetition/reinforcement
- Demonstrate verbal commands
- Immediate, positive feedback
- Provide instruction 1 step @ a time
- Structure activities/daily routine
- Acknowledge individual preferences



- Multiple external cueing
- Limit choices
- Optimize stimulation level
- Utilize over-learned skills
- Limit activities that require new learning
- Redirect as needed
- The 3 R's:

– REPEAT

– REASSURE

– REDIRECT (Weiner et al., 2003; Zec et al., 2008)

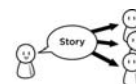


Basic Ground Rules:

- Everyone is a unique individual
- Everyone's input is valuable
- We can only control ourselves – not others
- Don't take behaviors personally
- Think about what the individual may be trying to tell us through their behaviors
- Timely, informative communication with clinicians



- There are no stupid questions or ideas
- Look for potential trigger(s) or changes
- Share ideas with others
- Know the person's story
- Stay positive & optimistic
- Document what works & what does not work
- Know the descriptions for specific behaviors
- What works today may not work tomorrow
- DOCUMENT!



Goals:

- **Improve QOL**
 - Self worth, meaning/purpose, hope, happiness, belonging, safety, contentment
- **Maintain function & independence**
- **Decrease care transitions**
- **Improve staff/family/clinician satisfaction**
- **Decrease use of antipsychotics**
- **Maintain appropriate medications at safest level for effectiveness**

**Getting Started:**

- **Identify individuals in practice with behaviors**
 - Clear definitions
 - Intrinsic or extrinsic factors
 - Scope & severity
- **Rule out new diagnoses/exacerbations**
 - Physical examination (PE); diagnostic tests per individual case
 - Reversible causes
- **Use of standardized rating scales & tools/instruments**

- **Medication review**
 - Look for adverse drug reactions (ADR), drug interactions (DI), drug-drug interactions (D-DI), side effects (SE)
 - Discontinue, hold, lower dose, switch
- **Know & practice the ground rules**
- **Documentation**
 - Type, frequency, triggers, severity, duration, safety issues, interventions; medication changes, gradual dose reductions (GDR)
 - Completed by ALL staff & family

“The initial approach to behavioral symptoms that do NOT present immediate danger to the individual or others should be nonpharmacological”

The American Geriatrics Society & American Association for Geriatric Psychiatry Expert Panel on Quality Mental Health Care in Nursing Homes, 2003

**Interventions
to
Enhance
Well-Being**



- **Get to know the individual**
- **It's not just *what* you do – it's *how* you make the person feel**
- **Know what the individual *can* do & support them in doing it**
- **Help the person to feel comfortable, safe & secure in their environment**
- **Remember – little things all add up**
- **See the person – *not the disease***
- **Incorporate care & compassion into practice**

- Presence
- Active listening
- Compassionate intention
- Person-centered
- Holistic approach
- Motivational interviewing (MI)



– “ Client-centered, directive method for enhancing intrinsic motivation to change by exploring & resolving ambivalence” (Miller & Rollnick, 2002, p. 25)

- Solution-Focused Therapy (SFT)
 - Focus is on what individuals want to achieve
 - Centered on future aspirations (Foot & Hopkins, 2010)
- Strength-Based Care Management
 - Promote use of support networks
 - Community involvement
 - Emphasizes relationships (Rapp, 2008)
- Narrative
 - People live their lives by stories/narratives they have created through life experiences & serve to shape their further life experience (Epston & White, 1992)



What Are Nonpharmacologic Approaches?

- Psychosocial, behavioral & environmental approaches/strategies with the potential for improving functioning in cognitive, self-maintenance, affective, spiritual & behavioral domains
- Provides an opportunity for constructive & meaningful interaction



Advantages:

- Addresses the psycho-social-spiritual-cultural-environmental potential reason for the behavior
- Holistic & person centered
- Avoids adverse side effects (ADRs), drug interactions (DIs), limited efficacy & potential harm
 - Medications can mask the underlying reversible need for intervention
- Preserves communication & interaction

- Preserves caregiver’s ability to properly care for the individual
- Creates an opportunity for attention & care (Rosenzweig, 2011)
- Creates memorable moments
- Focuses on the positive versus the negative
- Allows for joy, satisfaction, feelings of self worth, connectedness, FUN
- Improves/maintains QOL for all involved

Intervention Management:

- Psychological
- Behavioral
- Environmental
- Pharmacological
- Individualized
 - Need of the person
 - Type of BPSD
 - Previous response
 - Presence of co-morbid conditions



- **Key Elements of Management:**

- Clarification of target symptoms or behaviors
- Ruling out:
 - Delirium
 - Co-morbid major psychiatric diagnoses
- Creatively addressing possible:
 - Social
 - Environmental
 - Behavioral



} Remedies

Types of Interventions:

- Cognitive Stimulation Therapy (CST)
 - Function limited by cognition
 - Reality orientation
 - Skills training
 - Short term (ST)
 - Return to baseline
 - Better for individuals with stable deficits
 - Stroke

PLUS

- **Behavior Oriented (behavior modification)**

- Extinction: withhold positive reinforcement during inappropriate behavior
- Differential Reinforcement: reinforce positive or quiet behavior
 - Reinforcements: social, food, touch, going outside, etc.
- Stimulus Control: teach an association between a cue & behavior
- Physical & social activities, watching & listening, day care for restless behaviors

- Engagement with ritualistic observations
 - Spiritual & religious activities
- Exercise, removal of restraints, adequate rest (including pharmacological restraints)
- Individual, family, caregivers, staff
- Generally effective & long term (LT)
- Outcomes:
 - Positive impact on activities & ADLs
 - Consistent daily routines

Senior Day Program Activities:

- Indicated for mild to moderate severity dementia
- Structure group activities
- Stimulation-oriented therapies:
 - Exercise, crafts, pet therapies
- Social work counseling
- Guest speakers invited
- Trips



Social Interactions:

- 1 on 1 interaction 30 min/day x 10 days
 - Decreases verbally disruptive behavior
- 1st language
 - Reality orientation
- Pet therapy or owning pet
 - Decreases agitation & verbal aggression
- Group activity
- Simple games



- **Stimulation Oriented**

- Individual engaged in meaningful/pleasant activities of choice
- Improvements in disruptive behaviors & social isolation
- Behavior modification (*Rosenzweig, 2011*)
- Examples:
 - Recreational therapy
 - Art therapy
 - Pet therapy
 - Exercise therapy



- Aroma therapy (olfactory stimulation)
- Simulated presence: a personalized approach to enhance well-being
 - Video simulated presence (VSP) -
- Multisensory activities or sensory stimulation: anything that stimulates one of the 5 senses
 - Sight, hearing, smell, taste, touch

- **Minimize Impact of Sensory Deficits:**

- Wear clean corrective lenses (*decreases yelling*)
 - Get rid of old prescriptions
 - Lion's Club
- Clean hearing aid with functional battery that is actually in the ear (*decreases yelling*)
- Slow, repetitive explanation (*reduces confusion & agitation*)



- **Emotion Oriented**

- Improves emotional/social functioning by supporting the individual in coping with the cognitive/emotional/social consequences
- Modest improvement, if any
 - ST gains
- Examples:
 - Reminiscence therapy
 - Validation therapy
 - Supportive psychotherapy



NPAS

* = empirically supported; evidence based
No * = no research evidence to support use

- * Activities (*physical*)
- Art therapy
- Assistive devices
 - Eye glasses, hearing aids, canes, WC; shoes
- * Behavior plans (*individualized care plans*)
- * Communication
 - Slow, repetitive, simple explanations
- * Consistent daily routines
- * Coping strategies (*adaptive*)
- * Distraction/diversion
 - Person-centered
 - Everyone is a unique individual



- * **Education** (*staff & caregivers*)
 - Lack of intentionality
 - Dementia & delirium sx
 - Communication skills
 - Physical approach during ADLs & transfers
 - Focus on emotion versus content (validation)
 - Directions 1 step @ a time
 - Use of distraction versus logic
 - Predictable schedule
 - Use familiar staff



- * **Environment modification** (*depends on need*)
 - Can be:
 - Natural = mimic natural surroundings consisting or recorded bird songs, babbling brooks, small animals together with large bright pictures
 - Enhanced = simulated home environment with appropriate visual, auditory & olfactory stimuli
 - May decrease trespassing, exit seeking & agitation behaviors

- Reduced stimulation = designed with camouflaged doors, neutral colors/pictures on wall, no TV/radios/stereos/ringing phones
 - PLUS consistent daily routine
 - Soft & slow speech for communication
 - Decreases agitation & use of restraint



- Lighting, sound, temperature, smells
- Decrease stimulation
- Comfortable seating (*arms, back support*)
- Mattress (*pressure redistributing*)
- Bed height
- Positioning/repositioning (*neutral body alignment*)
- Smooth & tight linens
- De-clutter
- Placement of furniture
- Increase signage & access to toilets



- Improve time orientation
 - Clocks, calendars, staff names
- Small scale group living
- Calm, nontaxing environments
- Separate individuals with dementia from other residents
- No overhead paging system
- Minimize testing of fire alarms, weather alerts unless 1st talking with individuals (*PTSD*)



- Prominent placement of frequently required objects
- Soft wall colors
- Nonskid flooring
- Contrast between the wall & floor
- Handrails
- Wanderer's lounge
- Access to outdoor area; fenced
- Visual direction to different areas
 - Color lines; pictures



- * **Exercise** (*physical activity*)
- **Extinction, differential reinforcement & stimulus control**
- **Humor & laughter** 
- * **Hydration**
- **Hypnotherapy**
- * **Imagery** (*guided, visual*)
- **Light (photo) therapy**
- * **Listening**
 - **Active, reflective, intentional**
- **Logs** (*tracking: sleep, B&B, behaviors*)
- * **Massage/Touch** (*gentle/brief hand*)

- * **Music or music therapy (MT)** 
- * **Nutrition**
- **Observation** (*look, listen, smell, touch*)
- * **Occupational therapy (OT)**
- * **Pain reduction**
- * **Pet visitation; animal assisted therapy (AAT)**
- **Photography**
- * **Presence –being with; empathic**
- * **Rehabilitation or physical therapy**
 - **Optimizing ROM, strength, endurance, neuromuscular control**
- **Sleep hygiene**
- * **Social interaction**


- **Therapeutic use of self**
 - ***YOU are an intervention!***
- **Touch**
 - **Therapeutic (TT); healing**
 - **Rocking, holding, cuddle, hug, handshake**
- **Visits, telephone calls, Skype**
 - **Friends, family, health care professionals**



Care Manager

OUTCOMES



- **Improvement in QOL**
- **Maintain function** (*physical, mental, emotional, spiritual, social*)
- **Hope**
- **Socialization** 
- **Decreased morbidity & mortality**
- **Decreased # of health care transitions including ED & geropsychiatric admissions**
- **Decreased health care costs**
- **Improved job satisfaction for staff**



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