# Treatment of Behavioral and Psychological Symptoms of Dementia (BPSD)

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## Disclosure

- Contracted with Aegis Living and Horizon House Assisted Livings
- Instructor for Pacific Lutheran University
- The views and opinions in this presentation are those of the presenter

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## Objectives to cover:

- Prioritizing non-pharmacological/behavioral management to BPSD
- Key components to behavioral management: Realistic Expectations, Communication, ABCs, Pleasant Events
- Implementing DICE approach into the clinical visit
- Understanding and conveying limits of pharmacological nterventions for BPSD
- Integrating pharmacological intervention into treatment



## Non-pharmacological is 1st Line Tx: so let's treat it like it is!

- Medications are not that effective, have significant side effects, and doesn't solve the problem, so you need to do the 'non-pharm' interventions ANYWAY to have them be effective.
- Behavioral treatments:
  - Individualized to each person
  - Empower caregivers
  - Are useful at every stage of disease
  - CAN change behavior
- The Provider has to vouch for non-pharm approach, demonstrate its use, encourage its use, reinforce its use.

# What are non-pharmacological interventions?

- **Sensory stimulation interventions** (acupuncture, aromatherapy, massage therapy, light therapy, cognitive stimulation, **music**/singing/dance therapy
- **Cognitive/emotion-oriented interventions**: cognitive stimulation, reminiscence therapy, validation therapy, simulated presence therapy (SPT)
- **Behavioral management techniques**
- **Other**: exercise therapy, pet therapy, respite

Overall, **Music therapy** and **behavioral management** were effective for reducing BPSD.

Abraha et al., Review of non-pharm interventions for BPSD, BMJ, 2017.



# What are Behavioral Management concepts?

Per American Psychiatric Association: caregiver need to be educated on how to alleviate behavioral symptoms and learn these principles:

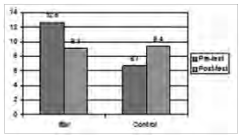
1. keep requests and demands relatively simple and avoid overly complex tasks that might lead to frustration
2. avoid confrontation and deferring requests if the patient becomes angered
3. remain calm, firm and supportive if the patient becomes upset
4. being consistent and avoiding unnecessary change
5. provide frequent reminders, explanations and orientation cues
6. recognize declines in capacity and adjusting expectations appropriately

# Implementation of Behavioral Management

- Seattle Behavioral Treatment Protocols key concepts:
  - Realistic Expectations
  - Communication
  - ABCs (behavior management)
  - Pleasant Events
- Content requires significant time to convey to target audience

STAR: A Dementia-Specific Training Program for Staff in Assisted Living Residences

Linda Teri, PhD,[1] Piruz Huda, MN, ARNP,[1] Laura Gibbons, PhD,[1] Heather Young, RN, PhD,[2] and June van Leynseele, MA[1]



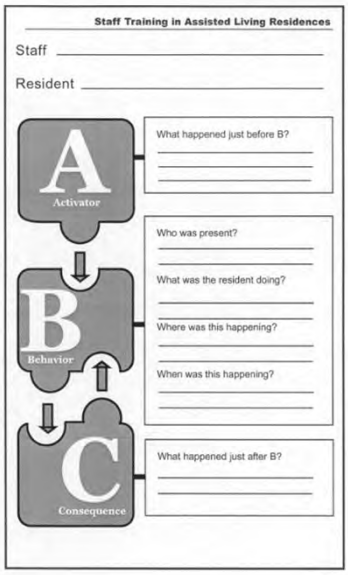


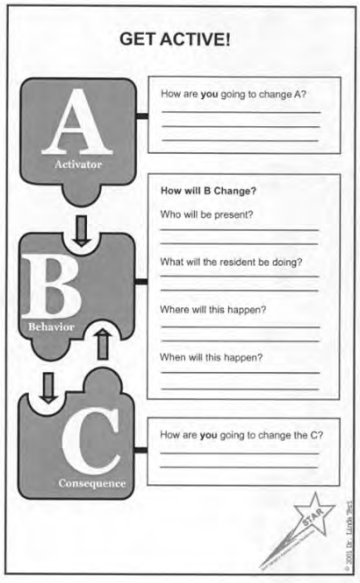
# The ABCs

Teri L, Huda P et al. STAR: Dementia-Specific Training Program for Staff in Assisted Living Residences, The Gerontologist, 2005

**Problem behaviors occur in three parts.**


- **Activator**
  **What happened just before B?**
- **Behavior**
  **What is the person doing?**
  **Where is this happening?**
  **Who is present?**
  **When is this happening?**
- **Consequence**
  **What happened just after B?B?**

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# Effective Communication as an intervention

- Emphasizing short cues, reassurance, non-verbal communications
- Listen with Respect, Comfort, Redirect

- Though seems like common sense, it is NOT typical for untrained caregivers

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## Pleasant Events as an intervention

- Cognitive impairment leads to loss of pleasant activities
- Decreased pleasant events can lead to boredom, behavior problems, and depression
- Caregivers can identify and implement pleasant events for the person with dementia
- A pleasant event is anything that can add pleasure to a patient's day.
- Every interaction has the potential to be a pleasant event.
- Pleasant events is everyone's job.



## Presenting Problem/Chief complaint:

- Cognitive symptoms: we cannot reverse nor fix
  - Complex attention, Executive function, Learning and memory, Language, Perceptual-motor, Social cognition
- Neuropsychiatric symptoms (NPS) to address/to treat/ presenting problem:
  - **Depression**: "she cries a lot…says she wishes she were dead…"
  - **Psychosis**: hallucinations, paranoia, intense mood swings
  - **Agitation:** yelling, extreme restlessness
  - **Aggression**: punching, kicking, biting
  - **Apathy**: "she doesn't want to do anything"
  - **Sleep disturbances:** up all night, sleeps during day
  - **Disinhibition**: masturbating in public, grabbing,
- Pharmacological intervention or non-pharmacological intervention?

# Certainly NOT pharm for:

- Unfriendliness
- Poor self care
- Memory problems
- Not paying attention or caring what is going on
- Repetitive verbalizations or questions
- Refusing care
- Shadowing, wandering

Kales et al, DICE 2014

<u>No for Antipsychotic in LTC</u>

- Wandering
- Refusing care
- Restless/fidgety
- Mild anxious, nervousness
- Inattentiveness
- Memory problems
- sadness,/crying
- Uncooperative

CMS, 2013

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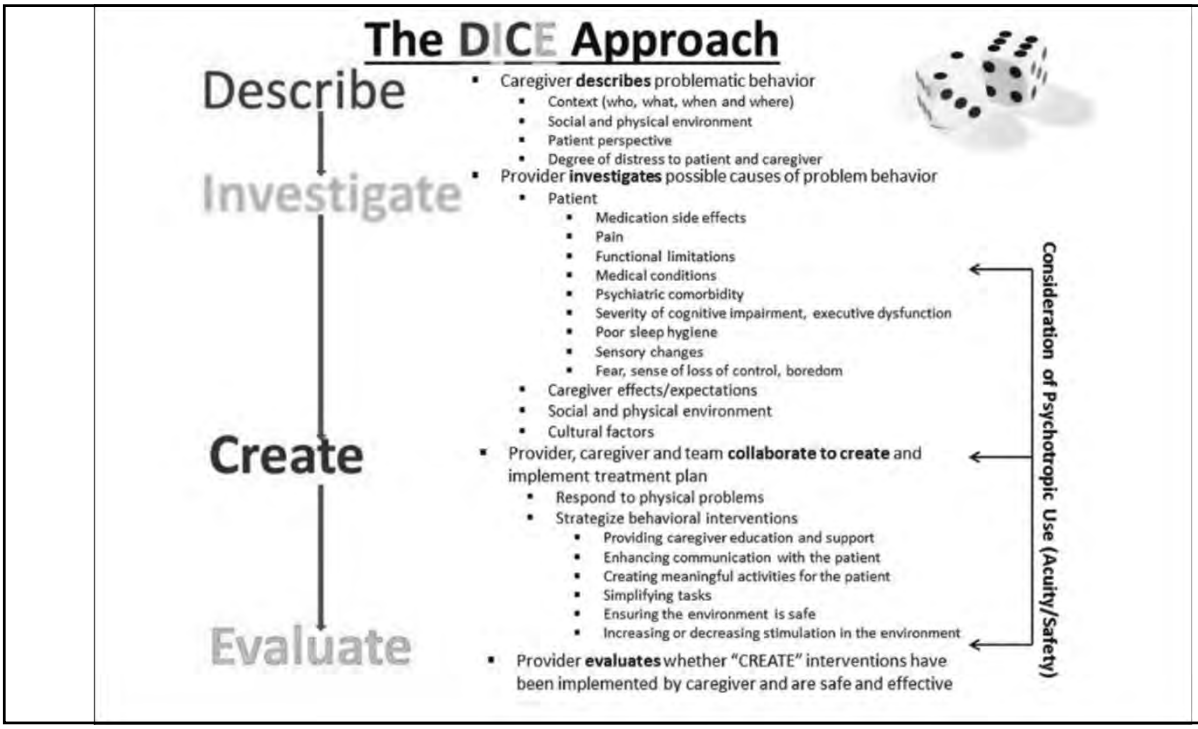


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## DICE Approach: For management of NPS in dementia: Kales et al, JAGS 2014

- DESCRIBE: Ask CG to play back the NPS 'as if in a movie'
  - From it, get the ABCs, specifics of NPS, and consequences, get the context for underlying modifiable patterns or contributory factors
  - Can ask CG to record them in Behavior log
  - patient perspective: elicit, distressed? was safety at risk?
  - caregiver perspective, considerations: distress? Safety risk?
  - Environmental considerations: what, who was there, when, where? What happen before and what happen after
- Pin down, what aspect of the symptoms is most distressing or problematic.
- From the description, you can evaluate the CGs knowledge of dementia and NPS and leads to specific strategies.

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## Identify: Target Behaviors: specific, observable , and interfere with care or QOL

Poorly described 'behaviors'

- She doesn't try to remember
- She is in denial about her disease
- He's confused
- He's depressed
- She's sundowning
- She's arguing all the time

Good examples of Target Behaviors:

- He refuses to get dressed
- She won't take her medication
- She cries a lot in the evening
- He wants to "go home" and tries to leave at night
- He sleeps all day and is up at night

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# Provider INVESTIGATES possible causes of problem behavior,

- Delirium work up?
- Medication side effects
- Pain
- Functional limitations
- Medical conditions
- Psychiatric co-morbidity
- Severity of cognitive sx
- Poor sleep hygiene
- Sensory changes
- Boredom
- Fear/sense of loss of control
- Caregiver expectations
- Social/physical environment
- Cultural factors
- Depression?

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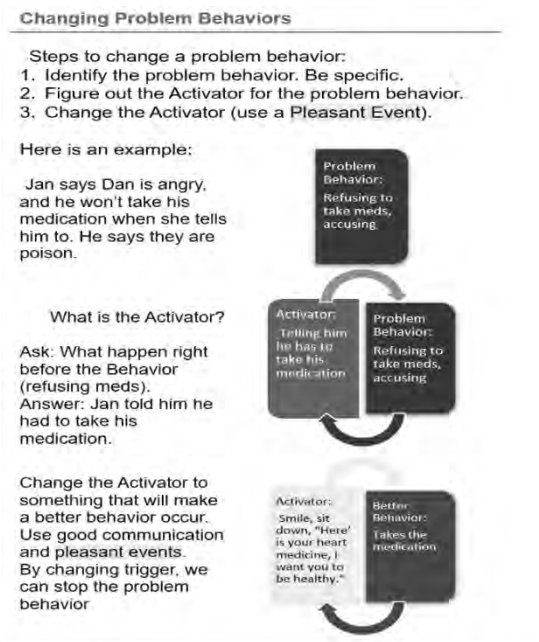
From huda-np.com

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# CREATE: collaborate to create and implement a treatment plan

- Provider, caregiver and team. Not being directive. Brainstorming.
- Strategize behavioral interventions.
- Respond to physical problems
- CG and pt leave with a plan: printed, specific, follow up identified
- Medications or not, IDENTIFY AND CHART TARGET BEHAVIORS. Be specific:
  - "striking out with care:" "refusing medications on multiple attempts, approaches." "crying episodes". "repetitive questions."
  - Specify the plan aka strategy aka treatment plan



# EVALUATE:

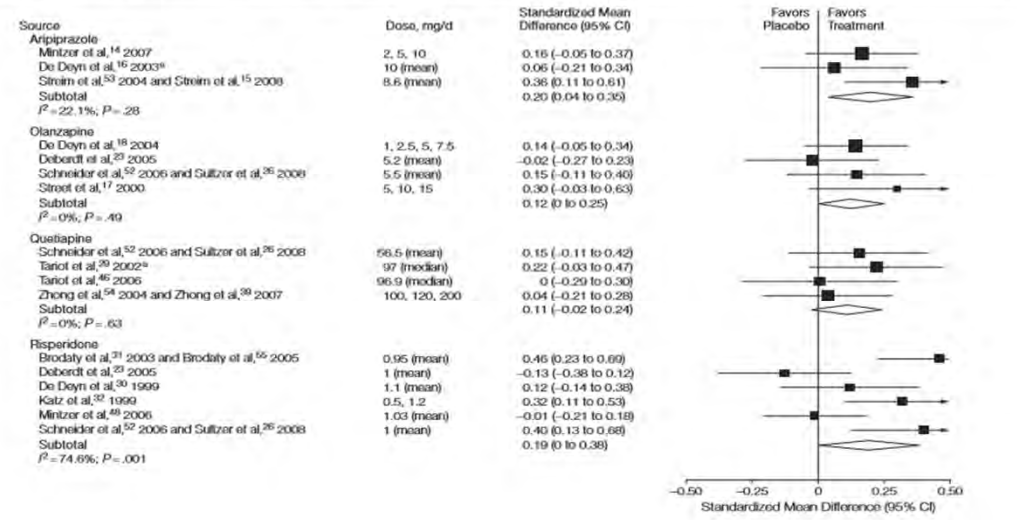
- Was the intervention implemented?
- Was it effective?
- Unintended consequences?
- If not implemented, why not?
- Go back to your documentation:
  - Target behaviors? Did plan get used?
- If using a medication, assess for efficacy, side effects, involuntary movements, falls
- Look for any changes. Check with the team.

# Know how effective medications are for BPSD

- Short answer: less effective than the treatments the medications (antidepressants, antipsychotics) were developed to treat, and carry significant safety risk for a population that is extremely sensitive to all medication side effects
- When treated with anti-psychotic, more than half had worsening of BPSD, while 1/3 had improvement in BPSD (Trinkley et al, 2018).
- Antidepressants have questionable efficacy
- Memantine separates from placebo for reducing BPSD, more often in moderate to late stage (Kishi, 2017)
- Regarding CBD: Friedman R. Is CBD Helpful or Just Hype, NYTimes, Dec 26, 2018.



**Figure 1.** Controlled Trials of Patients Taking Atypical Antipsychotic Medications vs Placebo




Total global scores are presented and include the symptoms of delusion, hallucination, dysphoria, anxiety, agitation or aggression, euphoria, disinhibition, irritability, apathy, aberrant motor activity, and behavioral disturbances. Weights are from a random-effects analysis. The size of the data markers is proportional to the sample size of the trial.

[a]The data used for this study were abstracted from the meta-analysis by Schneider et al.[10]

# Common Side effects when treating with antipsychotic medication

- EPS: extra-pyramidal symptoms (pseudo-Parkinson's)
  - Muscle stiffness
  - Gait changes
  - Leaning to one side
  - Akathesia: INCREASED physical restlessness
- Sedation
- Increased confused behaviors
  - Incontinence
  - Cannot use fork, cannot find room
- Flattened, depressed affect



# When a medication? When to stop?

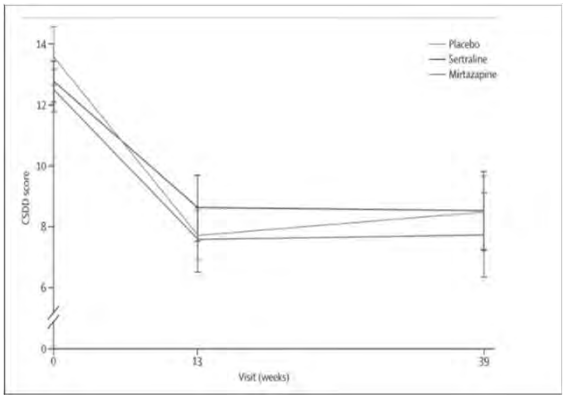
- Safety: risk to themselves or others?
- Distress: patient distress, caregiver distress
- Real world harm reduction: Preventing a hospitalization, preventing loss of housing
- Do they work? They can, but no guarantee

NNH: numbers of patients who receive tx that would be associated with one death, based on 180 day observation. –Maust et al, 2015 JAMA Psychiatry

| Medication | NNH |
|---|---|
| Haloperidol | 26 |
| Olanzapine | 40 |
| Quetiapine | 50 |
| Risperidone | 27 |
| Depakote | Comparable (Kales et al, 2012) |
| Antidepressant | 166 |

# How effective are antidepressants for dementia related depression?

Sertraline or Mirtazapine for Depression in dementia – Banerjee et al., Lancet, 2011.

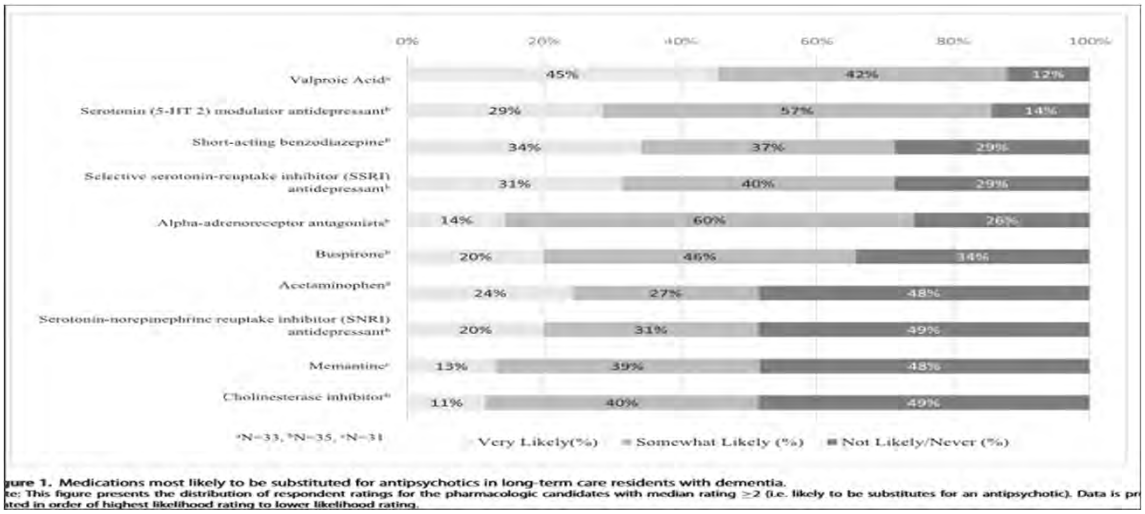



- Double blind, 9 centers in England.
- AD dx, depression over 4 weeks, and CSDD over 8.
- Sertraline, mirtazapine, placebo.
- 13 weeks and 39 weeks.
- 111 controls and 107 participants.
- Questions practice of first line treatment in AD.



# Perceptions vs evidence: therapeutic substitutes for antipsychotics in patients with dementia in LTC

Olivieri-Mui et al, Aging and Mental Health, 2017.




**gure 1. Medications most likely to be substituted for antipsychotics in long-term care residents with dementia.**
**te: This figure presents the distribution of respondent ratings for the pharmacologic candidates with median rating ≥2 (i.e. likely to be substitutes for an antipsychotic). Data is pr**
**ted in order of highest likelihood rating to lower likelihood rating.**

**Table 1.** Evidence for use of medications/pharmacologic classes most likely to be substituted for an antipsychotic in long-term care residents with dementia[a].

| Drugs | Quality of evidence[b] | Summary of evidence | Conclusions |
|---|---|---|---|
| Valproic acid | Strong | Not useful | Valproate preparations are not recommended for management of dementia. Valproate therapy is not effective in treating dementia-associated agitation and is associated with significant adverse effects. |
| Serotonin modulator antidepressant | Moderate | May be useful | Trazodone may reduce dementia-associated agitation and improve sleep in this population but evidence remains limited and safety concerns exist with its use in older adults. |
| Short-acting benzodiazepine | Moderate | May be useful | Short-acting benzodiazepines may improve time to sleep onset and reduce dementia-associated agitation but evidence is limited and benzodiazepines are associated with falls, delirium, and reduced sleep quality. |
| Serotonin reuptake inhibitor (SSRI) antidepressant | Moderate | Cautious use | Sertraline and citalopram are associated with modest reductions in dementia-associated agitation and psychosis. Serious safety concerns exist with their use in older adults. |
| Alpha-adrenoceptor antagonists (A1A) | Moderate | May be useful | Prazosin has comparable improvement in agitation and aggression to antipsychotics. Evidence of efficacy of other A1A drugs is lacking. |
| Buspirone | Weak | May be useful | Buspirone may reduce dementia-associated delusions, aggression, and anxiety but evidence is very limited and safety concerns, particularly in older adults, exist. |
| Acetaminophen | Moderate | May be useful | Acetaminophen may reduce dementia-associated agitation and discomfort in the context of an overall pain management protocol but evidence is limited. Few safety concerns exist. |
| Serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant | Moderate | May be useful | Dextromethorphan-quinidine may reduce dementia-associated agitation but the evidence remains limited and safety concerns exist with use in older adults. |
| Memantine | Strong | Useful | Memantine modestly reduces agitation in moderate to severe Alzheimer's disease. Safety concerns are minor. |
| Cholinesterase inhibitor | Strong | Useful | Donepezil, galantamine, and rivastigmine improve cognition in mild to moderate dementia. Safety concerns are minor. |

Note: [a]Presented in order of most likely to less likely substitute based on respondent rating.
[b]Strong = GRADE 4, Moderate = GRADE 3, Weak = GRADE 2.

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# In Conclusion….

- Prioritize non-pharmacological/behavioral management interventions for BPSD
- Emphasize effective communication, pleasant events, problem solving (ABCs)
- Specify and document target behaviors, indicate approaches identified for family/cg
- Medications to target BPSD have limited efficacy and are fraught with side effect and adverse event risks

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# References


- Banerjee et al, How effective are antidepressants for dementia related depression? Lancet, 2011.
- Kishi et al. Effects of Memantine on AD Behavioral Disturbances, A Meta-Analysis. Neuropsycyhiatr Dis Treat 2017.
- Trinkley et al., Efficacy and Safety of Atypical Antipsychotics for BPSD among community dwelling adults, Journal of Pharmacy Practice, April 2018
- Sue McCurry 2015 and David LaFazia 2013, Piruz Huda, 2017, Geriatric Healthcare Series, Northwest Geriatrics Workforce Enhancement Center
- Teri L, Huda P et al. STAR: Dementia-Specific Training Program for Staff in Assisted Living Residences, The Gerontologist, 2005
- Kales et al. DICE Approach For management of NPS in dementia. JAGS, 2014

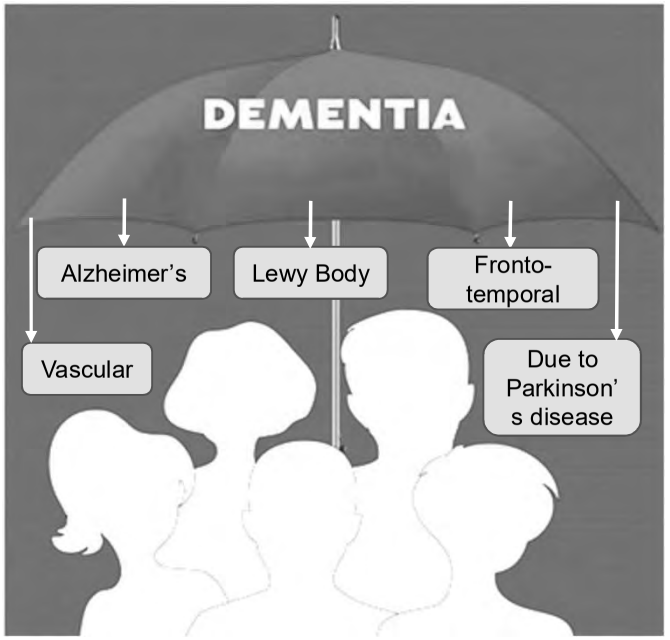
# Dementia: What We Can Do

1

## Dementia Overview

Dementia is not a specific disease. It is an overall (**umbrella**) term describing memory loss and other symptoms, including the loss of cognitive thinking skills which can interfere with daily life.

There are many different types of dementia, but the most common is Alzheimer's disease. Types of dementia include:




There are also several causes of reversible memory loss such as depression, medication side-effects, and other medical conditions which should be considered during a dementia evaluation. Head injuries, strokes, and alcohol and drug use can also increase the risk of memory loss and may lead to dementia.

2

## Dementia vs. Normal Aging

Dementia is not part of normal aging, but there is some memory loss associated with natural aging processes.

| Dementia | Normal Aging |
|---|---|
| • Memory loss frequently interferes with daily life | • Memory loss rarely interferes with daily life |
| • Difficulty performing familiar tasks | • Able to function independently |
| • Confusion with time, date, and place | • Forgetting which day it is and remembering later |
| • Frequently forgetting or misusing words | • May take longer to remember a word |
| • Trouble holding conversation | • No trouble holding a conversation |
| • Misplacing items and being unable to retrace steps to find them | • Occasionally forgetting where things were placed |
| • Change in mood and personality | • Same personality and mood; may be distracted |
| • Poor judgment and decision-making | • No change in judgment and decision-making skills |
| • Inability to manage a budget | • Missing a monthly payment |

*Note: This is not a diagnostic tool

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## Stages of Dementia

| Stage | Symptoms | Assistance Needed |
|---|---|---|
| Mild | Forgetfulness about recent events<br>Trouble problem solving or organizing thoughts<br>Difficulty with complex tasks (finances)<br>Mood swings or changes in personality | Minimal help<br>Assistance with finances and other complex tasks<br>More frequent check-ins for support and to see how doing |
| Moderate | Unable to recall address/telephone number<br>Confused about day or where they are<br>Poor judgment<br>Increased difficulty communicating<br>Able to distinguish familiar and unfamiliar faces, but trouble remembering names | Need some help with daily activities<br>Caregivers often take over all finances, grocery shopping, cooking, and driving<br>May need help with basic hygiene |
| Severe | Increase in personality and behavioral changes<br>Increase in wandering or getting lost<br>Lose ability to communicate | Help with all daily care (bathing, dressing, toileting) |

*Note: Some symptoms may overlap between stages. Symptoms vary from person to person.

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## Practical Communication

### 1. Eye Contact

- ☆ *Look directly at the other person when speaking or listening.*
- ☆ *Move eyes spontaneously and naturally.*

### 2. Body Position

- ☆ *Sit or stand directly in front of the person. Be sure you have his or her attention before speaking.*
- ☆ *Place yourself on the same level with the other person as much as possible. Do not stand over someone who is sitting or lying.*
- ☆ *Position yourself close enough to be seen and heard clearly, usually about three to six feet away.*

### 3. Face and Head Movements

- ☆ *Have a calm expression. Express changes on face appropriately.*
- ☆ *Nod appropriately and positively. Avoid a deadpan expression.*

### 4. Hand and Arm Movements

- ☆ *Use hand movements for emphasis.*
- ☆ *Use gentle touch to get or focus attention.*

### 5. Speech Rate and Tone

- ☆ *Speak slowly.*
- ☆ *Form and say words carefully.*
- ☆ *Use short sentences.*
- ☆ *Ask one question at a time. Wait for an answer before asking another question.*

***Be patient!***



5



## Listen with Respect, Comfort and Redirect

### Listen

**Make sure that the person KNOWS you are listening.**

- ☆ *Make eye contact with the person.*
- ☆ *Focus on the person; don't try to do two things at once.*

### Respect

**Sometimes being too casual with a person can be viewed as disrespect.**

- ☆ *Watch your tone of voice; no one likes to be scolded or talked down to like a child.*
- ☆ *Be careful when you talk about the person when he or she is in the room.*
- ☆ *Pay attention to the person's nonverbal communication. Does it seem like he or she is bothered by your communication style? If so, try a different way of communicating.*

### Comfort

**What we say and how we say it can provide a great deal of comfort to a person who is upset. Those who are anxious, agitated, or depressed can benefit greatly from comforting communication.**

- ☆ *Don't pay as much attention to what a person is saying as to what the person may be thinking or feeling.*
- ☆ *Let the person know that you understand.*
- ☆ *Persons with dementia who are anxious and depressed can't calm themselves down; they need help. A hug, a reassuring statement ("I will take care of you"), or even a "comfort item" such as a soft throw or pillow can be effective.*

### Redirect

**Sometimes providing comfort is not enough. Try to redirect or distract the person from his or her problem behavior.**

- ☆ *Attempt to change the subject after you have shown respect and tried comfort measures.*
- ☆ *Try to involve the person in a distracting pleasant event.*

***Whatever you do, DON'T ARGUE!***





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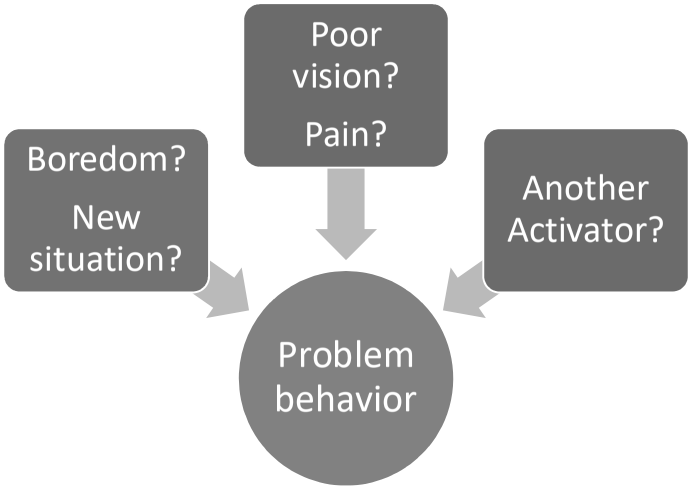
A person with dementia loses the ability to calm themselves or to cope with everyday stress, something those of us with functioning brains take for granted. They can be easily overwhelmed by the smallest of causes or **Activators**, resulting in a Problem Behavior.




Remember that these behaviors are part of the disease and are not done 'on purpose,' nor are they intended to be hurtful or frustrating.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## Target/Problem behaviors need to be
## - specific (when, where, what)
## - observable
## - interfere with care or quality of life

Good examples of:

- He refuses to get dressed
- She won't take her medication
- She cries in the morning
- He wants to "go home" and tries to leave at night
- He sleeps all day and is up at night

Not going to help: (vague, adds judgement)

- She doesn't try to remember
- She is in denial about her disease
- He is manipulative
- He is depressed
- She's sundowning
- She's arguing all the time

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## Common Behaviors That Can Be Challenging

- Waking you or other family members up at night
- Expressing feelings of hopelessness or sadness about the future
- Crying and tearfulness
- Toileting in inappropriate places
- Getting lost inside or outside of the house
- Talking about feeling lonely
- Comments about feeling worthless or being a burden to others
- Arguing, irritability, and/or complaining
- Physically threatening or aggressive towards others
- Getting dressed incorrectly or inappropriately
- Not shaving, washing, brushing teeth, or showering
- Refusing to accept appropriate help with personal care
- Trying to leave (or leaving) the house
- Restlessness, fidgetiness, inability to sit still
- Asking the same question over and over
- Repeated requests for attention or help (includes nagging, pleading, calling out).
- Walking back and forth or wandering aimlessly
- Having temper outbursts, including verbal or non-verbal expressions of anger
- Grabbing or clinging to you or other people physically
- Following you around everywhere you go
- Seeing or hearing things or people that aren't there
- Not wanting to do activities s/he used to enjoy
- Doing activities "wrong" or unsafely (e.g., cleaning, laundry, cooking, driving)
- Accusing people of stealing



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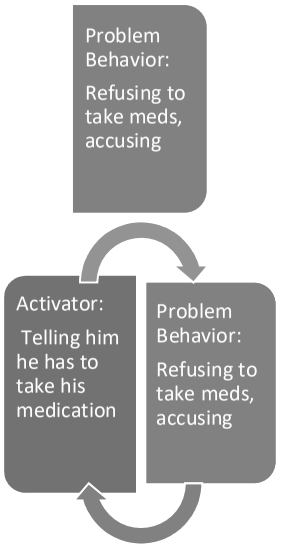
## Changing Problem Behaviors

Steps to change a problem behavior:

1. Identify the problem behavior. Be specific.
2. Figure out the Activator for the problem behavior.
3. Change the Activator (use a Pleasant Event).

Here is an example:

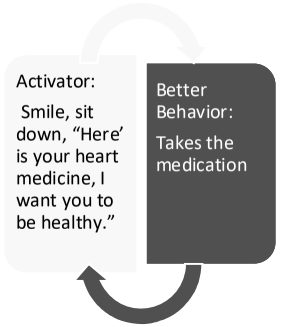
Jan says Dan is angry, and he won't take his medication when she tells him to. He says they are poison.




What is the Activator?

Ask: What happen right before the Behavior (refusing meds).
Answer: Jan told him he had to take his medication.

Change the Activator to something that will make a better behavior occur. Use good communication and pleasant events. By changing trigger, we can stop the problem behavior

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## Changing Problem Behaviors

Problem Behavior:

Goal Behavior:

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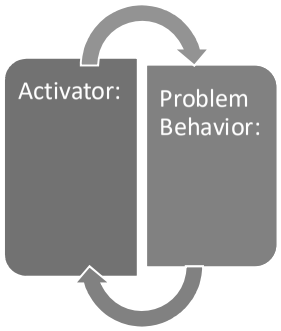


Change the Activator to something that will make a better behavior occur.
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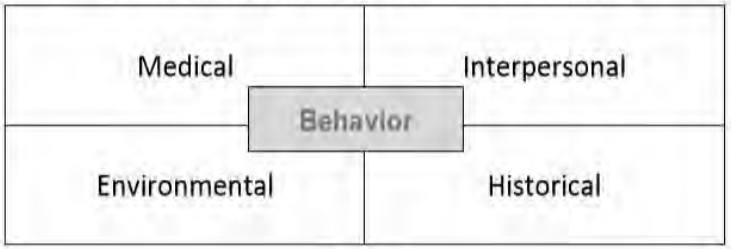
## Common Activators of Behavior Challenges




***Examples***

**Medical**
- Infection
- Pain or physical discomfort
- Adverse medication effects
- Incontinence or constipation
- Dehydration
- Fatigue or sleep deprivation
- Sensory loss

**Interpersonal**
- Being asked too many questions
- Being bossed around
- Impatient, critical tone of voice
- Offering "help" when it's not wanted
- Frustration at not being understood
- Being rushed
- Being touched or held in ways that are frightening or confining
- Verbal reasoning and logical explanations

**Environmental**
- Too much noise, activity, clutter, people, space
- Unfamiliar persons, places, things
- Startling movements, noise, or touch
- Insufficient lighting, visual contrast
- Changes in schedules and routines
- Being left alone for too long
- "Missing" objects or persons
- Lack of orientation cues

**Historical**
- Cultural background
- Past habits and preferences
- Family and social routines
- Religious beliefs
- Family, work, and social roles
- Lifelong personality style
- Education and occupation
- Traumatic events



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## Problem Behaviors and What You Can Do

We want to encourage those with dementia to have as high a quality of life as possible. However, problem behaviors can interfere with this, causing increased distress for the individual and those around them.
Try to identify causes or triggers for these behaviors and work to reduce them. Remember: Someone with dementia can't "just calm down," they need your help to do this!

### Anxious behaviors: yelling, arguing, throwing things

| Common Activators: | How to Respond: |
|---|---|
| Changes in routine (such as loss of spouse, or move to nursing home, or too much noise, or different caregivers, or travelling). | Keep requests simple to avoid frustration with complex tasks. |
| New environment or sounds. | Look for a trigger. |
| Boredom, not knowing what to do. | Avoid the triggers to prevent the problem behavior. |
| Pain | Calm the environment. |
| Trouble communicating | Give reassurance that things are fine, smile, help them be calm. |
| | Distract them with an activity such as a walk, a picture or a snack (Pleasant Event) |

### Hallucinations*: seeing or hearing things that are not real

| Common Activators: | How to Respond: |
|---|---|
| Dementia | See the doctor to identify cause. |
| Impaired vision or hearing | Try to address the vision or hearing issues. |
| Infections | Modify the environment. |
| Dehydration | Do not argue. Instead, try to provide reassurance that they are safe, then engage in a Pleasant Event. |
| Alcohol & drugs | |
| Medications | |
| Vision or hearing problems | |
| Schizophrenia | |

**Some hallucinations may be pleasant and not bothersome. Often nothing needs to be done about this type of hallucination.*

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### More Confused: cannot pay attention, more disorganized

| Common Activators: | How to Respond: |
|---|---|
| Infections, sickness. | Have medical evaluation to rule out reversible causes. |
| New medication. | Stay calm, provide reassurance. |
| Dehydration. | |
| Progression of dementia. | |
| New situations. | |

### Paranoia: irrational beliefs, accusations, suspiciousness

| Common Activators: | How to Respond: |
|---|---|
| Misplaced and forgotten items. | Stay calm, be comforting. |
| Unfamiliar situations or people. | Don't argue; provide reassurance they are safe, and then try to distract with a Pleasant Event. |
| Infections, sickness. | Have medical evaluation to rule out reversible causes. |
| Poor vision or hearing. | |

### Wandering

| Common Activators: | How to Respond: |
|---|---|
| Boredom. | Keep a regular schedule. |
| Too much energy. | Regular exercise, walks. |
| Can't remember where they are. | Avoid busy places. |
| Restless. | Camouflage doors. |
| | Use alarms and locks for safety. |
| | Provide supervision. |
| | Keep keys out of sight. |

### Sundowning* & Sleep Difficulties

| Common Activators: | How to Respond: |
|---|---|
| Fatigue. | Keep a regular schedule. |
| Reduced lighting. | Be active during the day. |
| Less need for sleep. | Stay calm. |
| | Prevent fatigue by early nap. |

**__Sundowning__ refers to increased behavioral problems that begin at dusk and last into the night.*

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## Do's and Don'ts: To Prevent Problem Behaviors

### DO

- **Remain** calm
- **Listen** to the person's complaints
- **Respect:** demonstrate that you respect them
- **Avoid** confrontation
- **Provide** reassurance with calm, supportive tone
- **Distract** from the trigger with a Pleasant Event
- **Discuss** successful strategies with others
- **Identify** the who, when, why, and what of challenging behaviors
- **Speak** slowly while reassuring the person, make eye contact, and place your body at their level
- **Cue** "Oh, here's Jenny, your niece, its nice to see her."
- **Encourage** "Can you do me a favor…?"

### DON'T

- **Say "**Don't you remember?"
- **Say:** "You need to do…"
- **Take** personal offense
- **Raise** your voice
- **Become** confrontational
- **Crowd** the person
- **Approach** the person from behind or too quickly
- **Attempt** physical contact
- **Tease** or ridicule the person
- **Show** fear, alarm, or anxiety
- **Use** physical restraint

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## Depression and Pleasant Events

Common symptoms or behaviors of depression include:

- Sadness
- Crying
- Change in appetite or sleep
- Negative or hopeless statements
- Loss of energy
- Easily irritated
- Thoughts of death or suicide

Inform your medical provider of symptoms of depression. Depression is complex, and treatment can significantly improve quality of life.

Just like with other problem behaviors, depression can happen because the person with dementia don't know how to cope with how they feel, such as feeling sad, bored, or irritable.
They need our help to change how they are doing or feeling.
A Pleasant Event is ANYTHING that can cheer someone up.
Adding pleasant events has been proven to relieve depression symptoms in those with dementia.

**Pleasant Events can reverse depression behaviors**

Activators for depression: remembering sad event, boredom, being alone or isolated , negative self talk.

Pleasant Events:

Cup of coffee, compliments, reminiscing of positive memories, going for walk, watching a movie, sharing a laugh



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## Treatment Options

Dementia is a disease that slowly worsens. Unfortunately, there is no cure. However, there are some therapies that might help slow down the progression.

### Suggestions for those with memory loss

- Exercise regularly
- Eat Healthy
- Get plenty of sleep
- Brain exercises such as crossword puzzles
- Learn new things
- Read challenging materials

### Medications for Dementia?

For some people, there are medications a doctor may offer to help slow the rate at which dementia worsens and maintain cognitive function for as long as possible, such as donepezil, rivastigmine, or memantine.

### Medication for problem behaviors?

Sometimes a doctor may consider a medication to reduce problem behaviors or to reduce anxiety or depression. However, their effectiveness is not guaranteed, and they can have side effects. The decision to use a medication is not made lightly.

Using the information and problem solving strategies in this manual is the "first-line treatment" for problem behaviors. Medications may be tried if the behaviors are causing severe distress or safety issues.
Know that at best, any medication is only going to be effective if you use the information and techniques from this manual.

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## References


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Please see website for more ideas and ways to respond.


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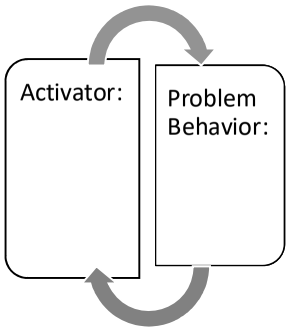
## Changing Problem Behaviors

Problem Behavior:

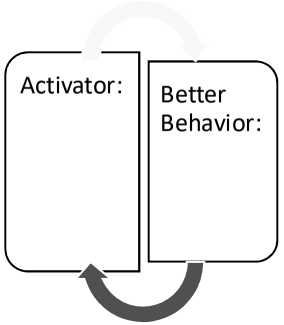
Goal Behavior:

What is the Activator?

Ask: What happen right before the Behavior (refusing meds).




Change the Activator to something that will make a better behavior occur. Use good communication and pleasant events. By changing trigger, we can stop the problem behavior

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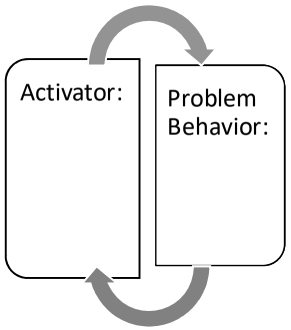


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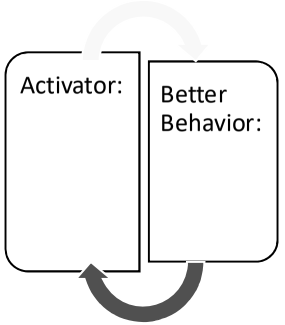


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