Behavioural and Psychological Symptoms of Dementia

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- "Signs and symptoms of disturbed perception, thought content, mood, or behaviour"
- Complex, costly, stressful for patients and carers.

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Psychological

- Anxiety (worrying/ ruminating/ panicking)
- Depression or low mood (tearful, unhappy, suicidal)
- Psychotic symptoms: Delusions and hallucinations

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Behavioural

May be interrelated or secondary to psychological symptoms. Eg anxiety → wandering and agitation.

- Aggression: Verbal or physical
- Agitation (upset, arguing, shouting, pacing, calling out)
- Rejecting care
- Disinhibition (sexual or physical/verbal)
- Motor "driven" behaviours eg rummaging, pacing
- Sleep disturbance – often in combination

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Nearly all people with dementia (95%) experience one or more at some stage.

Occur across all dementia subtypes – although patterns:

- Depression common in Vascular
- Anxiety and depression – early stages of Alzheimer's
- Executive dysfunction – FTD
- Agitation and apathy: common across all subtypes, persistent, may progress
- Delusions, hallucinations and aggression more likely to be EPISODIC and commoner in MODERATE stages.

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Impact on care and carers

- Poorer care outcomes
- Carer stress/ distress/ burnout
- Care break-down
- **Wandering, restlessness, care refusal and sleep disturbance are among the most problematic**

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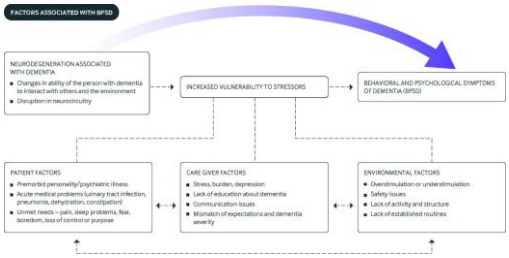

Taken from:
https://www.bmj.com/content/350/bmj.h369

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Factors related to patient

- Neurobiology (disruption to serotoninergic and dopaminergic pathways, frontal circuits – motivation and inhibition)
- Young onset (higher prevalence and often higher risks)
- Acute medical conditions/ PAIN
- Poor hearing or eyesight
- Unmet needs (communication)
- Pre-existing personality and mental health

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Factors related to carers

- Higher rates of depression, ill-health and stress among carers for dementia vs other conditions.
- Carer stress/ anxiety/ depression impacts person with dementia
- Carer communication (eg shouting or tearful)
- Variable implementation of treatment plans and behavioural strategies.

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Environmental factors

- Dementia → stimulus processing and response difficulties
- Progressive drop in stress threshold → higher frustration levels
- Changes in routine, unfamiliar setting, competing stimuli or demands, lack of stimulation are all potential triggers.

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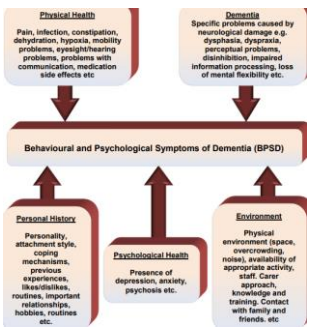

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Assessment

- Rule out delirium
- Consider additional patient factors eg constipation, pain, impaired hearing – often multifactorial rather physical OR psychological.
- Carers (training, stress)
- Environment (noise, safety, triggers)

- Assessment of behaviour: ABC approach

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Treatment: Non-pharmacological

1. The patient:

Physical activity; music therapy; reminiscence; 1:1 contact; recordings of family

2. The carers:

Education/training; carer support

Specific carer-based intervention programs eg TAP – identifying triggers and tailoring responses

- **Best evidence-base overall is for carer-focused interventions; also no iatrogenic harm.**[1]

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Treatment: Non-pharmacological

3. Environment:

- Remove excess stimulation (noise, bright lights, doors slamming, shouting)
- Address under-stimulation, loneliness, boredom
- Structure and routine

- Limited RCT data but positive outcomes in various measures and trials

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Treatment - pharmacological

The evidence base is poor for a lot of drugs we use.

Carer interventions, behavioural pathways and dementia mapping/psychology input are lengthy and expensive.

Drugs are generally cheap

As doctors we feel the need and pressure to do "something"

Key principals:

Start low, go slow.

Discuss and consider risks and benefits.

Try stopping antipsychotics at least once (realistically – ideally it should be reviewed every 6 weeks).

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Treatment: Pharmacological (1) – Cognitive enhancers

No real evidence for either Cholinesterase Inhibitors to treat agitation [1]

However – Memantine does seem to be protective against BPSD: a strong case to start it proactively.

If Memantine is indicated and there is mild restlessness/agitation – this is a reasonable starting point.

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Treatment: Pharmacological (2) – Antidepressants

- Citalopram works for less severe agitation. Dose-dependent so try at least 20mg (CIT-AD study). May be better response at 30mg if tolerated. Works better in less impaired people and takes avg 3 weeks to work.[1]

- Limited evidence for other antidepressants in agitation although Trazodone and Mirtazapine often used for night sedation.[2]

- For depression in dementia – no good evidence for antidepressant medication on population level, although likely "subgroup" where they do work. Includes Mirtazapine and SSRIs. What DOES work is CBT and "treatment as usual" – ie CMHT input.

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Treatment: Pharmacological (3) – Antipsychotics

- These treat AGITATION – they do not seem to treat psychosis.
- Risperidone is first line for BPSD; licensed as short-term treatment (6 weeks). Dose 0.25mg – 2mg daily. Better responses at higher doses.
- If not tolerated or no benefit can trial Olanzapine, initially 2.5mg ON. More sedating.
- Evidence gets poorer for other antipsychotics.
- Lewy Body or Parkinson's: caution needed. Low dose Quetiapine or Clozapine if significant risks.
- Good evidence there will be no "relapse" if stopped after 6 weeks – we should at least try.

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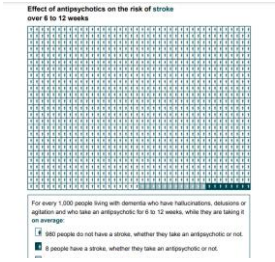
- https://www.nice.org.uk/guidance/ng97/resources/antipsychotic-medicines-for-treating-agitation-aggression-and-distress-in-people-living-with-dementia-patient-decision-aid-pdf-4852697005



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Treatment: Pharmacological (4) – Benzodiazepines

- Often used in acute crises
- May be helpful if predictable trigger eg half an hour before attempt to wash, if severely agitated.
- Risks of falls/ dizziness/ oversedation/ increased confusion/ disinhibition
- Very little evidence on efficacy (either positive or negative)

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BPSD summary:

- Consider acute delirium
- If ruled out: consider simple modifiable risk factors. Environmental, clear triggers/ pattern, pain. **Carer factors: refer to PROMAS or admiral nurse?**
- Carer interventions have a better evidence base without the harmful side effects.
- For agitation, the drugs with the best evidence base are Citalopram and Risperidone.
- Antidepressants don't work for depression in dementia as a population
- Avoid Benzos unless acute crisis or very limited specific PRN eg just before care.
- Memantine is protective – start it proactively.

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Referrals:

- If in care home – involve Dementia Liaison Nurse if available.
- Research: trials for DLB and Parkinson's hallucinations
- Consider old age psychiatry (DOPMH) if:
  - Own home or in care home not covered by DLN
  - No response to initial simple measures/treatments
  - Significant risks to patient or others
  - Consideration of antipsychotics
  - Complex social situation, need for more intensive monitoring

I am always happy to answer emails for medication advice/ referral discussions

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Useful resources

https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/symptoms/managing-behaviour-changes (for carers)

https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2022/10/Antipsychotic-Prescribing-Toolkit-for-Dementia.pdf

https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#managing-non-cognitive-symptoms

https://www.bmj.com/content/350/bmj.h369

(BMJ Review of Best Practice – Assessment and Management of Behavioural and Psychological Symptoms of Dementia).

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References

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https://doi.org/10.1176/appi.ajp.2016.15020248

(CIT-AD Trial: Citalopram for BPSD)

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