Treating Behavioral Disturbances in Dementia, Using Evidence to Optimize Care

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Behavioral disturbances in dementia are a group of non-cognitive symptoms and behaviors that occur frequently in patients with dementia [1]. They can be defined as a heterogeneous range of psychological reactions, psychiatric symptoms and behaviors that are unsafe, disruptive and impair the care of the patient in a given environment [1].

Behavioral disturbances occur in about a third of community-dwelling people with dementia but their prevalence rises to over 80% in patients admitted to skilled nursing facilities [1]. Unlike cognitive symptoms of dementia which decline over the course of the illness, behavioral disturbances often fluctuate with agitation being the most persistent symptom [1].

Behavioral disturbances in dementia can be grouped into different symptom clusters [2]. These include the psychotic cluster (delusions and hallucinations), agitation, mood disorders cluster (depression and anxiety; apathy-indifference), aberrant motor behavior cluster (pacing, wandering, and other purposeless behaviors) and inappropriate behavior cluster – disinhibition and euphoria. Apathy appears to be the most common behavioral symptom in dementia with a prevalence rate of 48% to 92% [3].

Available data indicates that behavioral disturbances in dementia occur due to a complex interplay between neurobiological changes associated with dementia, psychological traits and genetics [1,4]. Neurobiological changes include pathological and functional changes within the frontal, parietal and temporal cortices and the basal ganglia. High levels of neuroticism predispose patients to these behaviors. Genetics of behavioral disturbances in dementia include the presence of APOE3/4 genotype and the polymorphisms of the serotonin and dopamine receptors [1].

The presence of behavioral disturbances in dementia is associated with significantly higher social and economic burden of care [1]. They also increase the risk for institutionalization for these patients. These behaviors are associated with a faster cognitive and functional decline and a worse quality of life. They also add to the direct and indirect costs of caring these patients [1].

Evaluation of patients with behavioral disturbances in dementia must include a thorough medical and psychiatric history [5]. Common reversible conditions including metabolic, infectious and nutritional and neurovascular disorders must be ruled out. The effect of medications on the development of these symptoms should be evaluated. The use of standardized rating scales assist in qualifying and quantifying these behaviors and aid in monitoring their progress during treatment [6].

Current evidence indicates efficacy for both non-pharmacological and pharmacological treatments for behavioral disturbances of dementia [7]. Pharmacotherapy is usually reserved for those patients who have had an inadequate response to non-pharmacological interventions and is often used in combination with the non-pharmacological interventions [7].

A systematic review of evidence indicates that caregiver and residential care staff education and possibly cognitive stimulation in patients appeared to have lasting effectiveness in the treatment of behavioral disturbances in dementia [8]. Behavioral management techniques centered on individual patient’s behavior are often successful for the reduction these behaviors. Availability of supports systems for the patients and their caregivers with greater time for self and providing education and training to the caregivers reduce caregiver burden and have a positive impact on the patient behaviors thus delaying institutionalization [7].

Meta-analytic evidence indicates that atypical antipsychotic medications; risperidone and aripiprazole have some albeit modest effects on the treatment of behavioral disturbances in dementia [9]. Available data indicates limited benefit for olanzapine and quetiapine for the treatment of these behaviors [7]. The use of these medications is limited by their side-effect profile and associated direct and indirect costs. Current data does not indicate significant benefit for these medications in reducing the financial costs and the burden of care of these patients [7].

The data on the use of anticonvulsants in the treatment of behavioral disturbances is disappointing with limited benefit noted for carbamazepine [10]. Antidepressants especially selective serotonin reuptake inhibitors have shown some benefit in treating the mood disorder cluster of symptoms but again this data is limited [11]. Benzodiazepines have minimal role in the treatment of behavioral disturbance in dementia given the lack of data on their efficacy and significant adverse effects. Cholinesterase inhibitors and memantine have limited data on treating behavioral disturbances in dementia although they may delay the emergence of these symptoms by delaying the cognitive decline [7].

Recent concerns on the use of psychotropic medications in the treatment of behavioral disturbances in dementia especially the antipsychotics include the increased risk of cerebrovascular adverse events and death [12]. Available evidence indicates that the risk is similar for all the different antipsychotics. Emerging data implicates the valproic acid derivatives and benzodiazepines with similar risks [13,14]. The risk for these adverse effects appears greatest within the first month of treatment initiation and the risk remains for up-to two years. The risk for these adverse events is higher in older patients and those patients with vascular dementia, more severe stages of dementia and in patients with cardiovascular risk factors and functional

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impairments [12].

Given the current state of evidence, it is clear that the assessment and treatment of behavioral disturbances in dementia needs further refinement. A thorough medical evaluation will aid in the diagnosis and treatment of medical conditions that can cause or worsen these behaviors. This medical evaluation can assist in the prevention of unnecessary exposure to psychotropic medications. The use of standardized assessment scales can qualify and quantify these behaviors. They can assist with the assessment of severity or the stage of dementia. Education of the staff and caregivers along with cognitive simulation in the patients can reduce the frequency and severity of these behaviors. For those behaviors resistant to non-pharmacological interventions, pharmacotherapy can be instituted. Careful clustering of symptoms, identifying target symptoms, using medications that have best evidence in treating these target symptoms, close monitoring of symptom improvement with frequent assessment for adverse effects of medications can maximize gain and minimize loss with pharmacotherapy. The combination of non-pharmacological and pharmacological treatment modalities appear to have a synergistic effect and should be the norm and not the exception for the treatment of more severe behaviors. As newer data emerges for the assessment and treatment of behavioral disturbances in dementia, this data should be added to the treatment algorithm to optimize outcomes for these patients and their families.

References