Therapeutic interventions in dementia 2: non-cognitive symptoms

The management of non-cognitive symptoms and challenging behaviour in people with dementia

INTRODUCTION

Non-cognitive symptoms of dementia include delusions, hallucinations, depression, anxiety, agitation and associated behaviours. They often take the form of a co-morbid emotional disorder and can encompass ‘behaviour that challenges’. This includes aggression, marked agitation, wandering, hoarding, sexual disinhibition and disruptive vocal activity such as shouting.

It is thought that up to 90% of people with Alzheimer’s disease have such symptoms (Robert et al, 2005). Although the difficulties reflect distress patients may be experiencing, other people’s reactions to such behaviour may also add to patients’ discomfort.

It is important that the context and reason for the non-cognitive symptoms, especially challenging behaviour, are understood. For instance, wandering may be due to a wish to escape from the immediate environment, or the person may be looking for someone or something, or experiencing restless agitation, boredom or a need for exercise.

Treatment should reflect possible causes of non-cognitive symptoms and assess whether the behaviour is a serious problem for patients or care staff. NICE and SCIE (2006) emphasise the importance of not seeing such behaviour solely as a symptom of dementia but as resulting from psychosocial and/or biological factors. It is therefore crucial for care staff to be able to differentiate and distinguish the factors or difficulties leading to a particular behaviour so that tailored treatment can be offered. Anticipating and addressing the causes of challenging behaviour can obviate the need to use potentially harmful drug treatments.

PHARMACOLOGICAL INTERVENTIONS

Pharmacological interventions should only be considered for non-cognitive symptoms or challenging behaviour as first line treatment if patients are severely distressed or if there is an immediate risk of harm to themselves or others. Patients should be assessed and the care-planning approach used (see Box 1).

Antipsychotic drugs should not be used for mild to moderate non-cognitive symptoms in dementia with Lewy bodies (because of a risk of severe adverse reactions) and in Alzheimer’s, vascular dementia or mixed dementia (because of an increased risk of cerebrovascular adverse events and death). Antipsychotic drugs may be considered for severe non-cognitive symptoms (such as

LEARNING OBJECTIVES

1. Understand underlying reasons why patients may present with behaviour that challenges.

2. Be aware of the main therapeutic interventions for non-cognitive symptoms and challenging behaviour.

possible factors influencing their behaviour (see Box 1).

For people who are very agitated the following interventions may be considered:

- Aromatherapy;
- Multisensory stimulation (also known as Snoezelen therapy, involves active stimulation of the senses using a room with appropriate lighting, sound and equipment);
- Therapeutic use of music and/or dancing;
- Animal-assisted therapy (which involves using companion animals to improve mood);
- Massage.

When deciding which therapy to offer, patients’ abilities, skills and preferences should be considered. Once therapy has started, their response should be monitored and the care plan adjusted accordingly.

NON-PHARMACOLOGICAL INTERVENTIONS

Typically the first line treatment for non-cognitive symptoms and challenging behaviour is a non-pharmacological intervention. Patients should be offered an assessment as soon as possible to identify

The following should be assessed:

- Physical health;
- Depression;
- Possible undetected pain or discomfort;
- Side-effects of medication;
- Individual biography;
- Psychosocial factors;
- Physical environmental factors.

Behavioural and functional analysis should be undertaken in conjunction with carers and care workers. Individual care plans should be developed and recorded in patients’ notes. These should be reviewed regularly with carers and other staff.

BOX 1. ASSESSMENT AND CARE-PLANNING APPROACH

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- Physical health;
- Depression;
- Possible undetected pain or discomfort;
- Side-effects of medication;
- Individual biography;
- Psychosocial factors;
- Physical environmental factors. Behavioural and functional analysis should be undertaken in conjunction with carers and care workers. Individual care plans should be developed and recorded in patients’ notes. These should be reviewed regularly with carers and other staff.

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This is a two-part unit on therapeutic interventions in dementia, based on NICE and SCIE (2006) guidance. Part 1 outlined management strategies for cognitive symptoms and how to maintain function. This second part examines interventions for non-cognitive symptoms.
Therapeutic interventions in dementia

Psychosis and/or agitation causing significant distress) only if:
- The risks and benefits of using the drugs have been discussed;
- Changes in cognition are regularly assessed and recorded. If there are differences, a change in medication should be considered;
- Target symptoms have been identified and recorded and changes are regularly monitored;
- Other conditions, such as depression, have been taken into account;
- The drug is chosen after an individual risk-benefit analysis;
- The dose is started low and titrated upwards;
- The treatment is time-limited and regularly reviewed (every three months or according to clinical need).

In people with dementia with Lewy bodies, severe adverse reactions, such as development or worsening of extrapyramidal features or acute, severe physical deterioration should be monitored for.

Recently published evidence from a three-year follow-up of a trial of antipsychotics compared with placebo in people with Alzheimer’s disease confirms the serious dangers of antipsychotic drugs in terms of increased morbidity and a halving of survival rates for those taking them (Ballard et al, 2009). This study highlights the importance of using antipsychotics as a last resort and, when they are used, of regularly reviewing them and discontinuing them wherever possible—the dangers of these drugs do not decrease with longer-term use. For indications on using acetylcholinesterase inhibitors, see Table 1 in Portfolio Pages.

CHALLENGING BEHAVIOUR

Any factors that increase the likelihood of challenging behaviour should be addressed, as this can be caused by, for example the person’s physical environment, psychosocial factors or physical health. Relevant factors include: overcrowding; lack of privacy; lack of activities; inadequate staff attention; conflicts between staff and carers; and weak clinical leadership.

Immediate management of such behaviour should take place in a low-stimulation environment, away from others. Drugs (benzodiazepines or antipsychotics) should be used to calm the person and reduce the risk of violence and harm rather than to treat any underlying psychiatric conditions.

The aim should be to reduce agitation or aggression without sedation. The lowest effective dose should be used and combinations of drugs should be avoided. Typically this should be an oral medication.

Drugs to control behaviour should be used with caution owing to risks of loss of consciousness, over-sedation, damage to relationships between patients, carers and the care team, and specific issues related to age and physical/mental health. If a drug to control behaviour is needed, it should be lorazepam, haloperidol or olanzapine.

CO-MORBID DISORDERS

People with dementia are more likely than the general population to have depression (Robert et al, 2005) and anxiety is also common. Therefore nurses should carry out assessments for co-morbid disorders.

Psychosocial interventions for co-morbid depression and/or anxiety include cognitive behavioural therapy and a range of tailored interventions such as reminiscence therapy, multisensory stimulation and exercise.

People with co-morbid depression should be offered antidepressant medication after a risk-benefit analysis. Drugs with anticholinergic effects should be avoided because they may adversely affect cognition.

REFERENCES


INTERVENTIONS FOR CARERS

Carers often need support themselves, particularly if the person they are caring for experiences severe non-cognitive symptoms (Donaldson et al, 1997). Compared with other carers, those supporting people with dementia are among the most vulnerable to stress, depression, feelings of guilt and other psychological difficulties (Brodaty et al, 2002; Sörensen et al, 2002).

Admiral nurses provide carer support, following a comprehensive assessment of patients’ and carers’ needs. Carers may be offered a range of interventions, such as individual or group psychoeducation; peer-support groups; support and information via telephone or internet; training on dementia, services and benefits; and involving other family members in family meetings. Support such as transport or short-break services, should be available to enable carers to take part in interventions.

Those who experience distress should be offered psychological therapy, including cognitive behavioural therapy.