# BEHAVIOUR MANAGEMENT: A GUIDE TO GOOD PRACTICE – MANAGING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

*by **The Dementia Collaborative Research Centre – Assessment and Better Care, University of New South Wales.** (2012) (Accessed: 1 May 2016)*

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This guide aims to assist clinicians in caring for persons with behavioural and psychological symptoms of dementia (BPSD) through a comprehensive evidence and practice-based overview of BPSD management principles. It offers practical strategies and interventions for care staff and caregivers. Modules in the guide include:

## Aggression

More common in men and linked to a premorbid personality trait of low agreeableness, its frequency and intensity tends to increase as dementia progresses and as cognition, activities of daily living, functioning and language abilities deteriorate.

- These are physically/verbally threatening behaviours (e.g., verbal insults/obscene language, violent behaviours or sexual aggression) directed at objects, self or others, which can arise from underlying depression, psychotic symptoms or unmet needs.
- Often occurs during personal care tasks involving close contact and can be due to a violation of personal space or perceived threat.
- Prevalent in Alzheimer's disease (AD) and vascular dementia; greater physical aggression occurs more in frontotemporal dementia than AD.

## Agitation

Symptoms of agitation overlap with aggressive behaviours and hyperactive delirium can also be misdiagnosed as agitation.

- These are observable, non-specific, restless behaviours that are excessive, inappropriate and repetitive, arising from strong disabling emotions.
- Can present as irritability; restlessness and/or pacing; unusual motor activities (e.g., excessive fidgeting or hand wringing); and/or disruptive vocalisations.

## Wandering

One of the most challenging and problematic behaviours, with up to 63 per cent prevalence.

- Classified as moderate and subclinical (largely based on duration and rate); involves trailing, pottering, increased motor activity, aimless/inappropriate/appropriate but excessive/night-time walking, attempts to leave abode and being brought back home.
- Causes vary and may include seeking a loved one, escaping from a perceived threat, being intrinsic to dementia-related brain pathology, and a habitual pattern of activity, reaction to medication, depression symptom, wish to return to a familiar environment (e.g., one's home), and response to pain, infection or bodily discomfort (e.g., constipation).

## Vocally disruptive behaviour

Prevalence rate depends on the inclusiveness of the definition and care setting. Cursing and/or verbal aggression are more prevalent than repetitious sentences/questions and screaming.

- These are caused by physical and/or psychological discomfort/social isolation, unmet needs, operant conditioning and reduced stress-threshold.
- Exhibited as intermittent or incessant vocalisations (e.g., singing, screaming, verbal aggression or abuse, preservation, repetitive questioning, groaning, sighing).

## Management

1. **Conduct a comprehensive assessment** and address potential underlying causes (e.g., urinary tract infection, adverse effects of medication).
2. **Use psychosocial methods first and address environmental factors,** unless the person is very distressed or at risk of harming themselves or others,
3. **Educate carers,** involving them in the management plan.
4. **Individually tailor appropriate psychological interventions.**
5. **Monitor symptoms first** before considering pharmacological therapy, as symptoms may resolve spontaneously or in response to psychosocial interventions.
6. **The person or the person's legal proxy must give consent,** before commencing pharmacological therapy.
7. **Dosage should start low, go slow and be reduced** after some time (e.g., three months).
8. **Monitor for adverse events,** as these can also present as BPSD.
9. **Review and reassess** BPSD symptoms and therapy regularly.

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