Psychoeducation and Behavioral Approaches in Cognitive Impairment and Dementia

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Disclosure/conflict of interest – Last 12 months

- I am not/have not been part of any speakers bureau

- Institutional Research Grants or clinical trials:
  - Novartis (observational cohort study), Global Alzheimer’s Platform, Synexus (Brain Health Registry, observational cohort study)

- Scientific/Medical/Data Monitoring Advisory Board, Consultation, lectures/CME programs, or Work Groups/Committees:
  - Alzheimer’s Association, Biogen, Eisai, Grifols, Harvard Medical School Graduate Continuing Education (HMS CE), Lundbeck, National Institutes of Health (NIH) Roche/Genentech, Suven, Synexus

- Book/Authorship:
  - Oxford University Press (OUP)
Effective Multifactorial Management of AD

Early detection, education, communication, care coordination & support → Diagnosis & Disclosure denied is Justice and Care Denied; and is HARMFUL

Non-Pharmacological: behavioral strategies; ongoing monitoring of health & safety and providing support to patient & caregivers

Pharmacological: reduce potential for harm; slow clinical decline using approved anti-AD medications; judicial use of other Rx as needed

Alliance with Patient-Caregiver Dyad
Care for Caregivers → Provide meaningful benefits to patients, families & caregivers

General Considerations – evidence-based medicine and opinion

- **ASSESS, EDUCATE, COUNSEL, RE-ASSESS** ...
  
  - Assess understanding (knowledge of facts) and appreciation (recognition that facts apply to the person) of the presence and severity of the Cognitive Behavioral Syndrome

- **New paradigms** for “necessary” supervision and monitoring; establishing habits and compensatory strategies, and communication paradigm (“a new language”)

- Remove deleterious medications; slowly start and maintain combination treatment with ChEI and memantine-add-on; treat exacerbating and comorbid conditions; promote quality sleep, life and health

  - **Reduce stress** – causes confusion and psychomotor slowing and is “toxic” in chronic state – via cortisol and adrenaline in chronic stress response

  - **Reduce excessive EtOH** intake

  - Promote restorative **sleep** (diagnose and treat sleep apnea); **sleep hygiene**

Promote general physical, social & mental activity and health:

- Good and balanced diet – much to be learned still; best data for MIND Diet
- Keeping mentally engaged with effortful mental activities (not to point of causing stress and frustration)
- **Exercise, Exercise, Exercise** – emphasize need for commitment to daily (or almost daily) exercise. Explain benefits:
  - improved circulation/blood flow to brain \(\rightarrow\) bring nutrients and O2; removing “toxic” proteins that accumulate;
  - delivery of growth (neurotrophic) factors important in synaptogenesis and neurorepair;
  - shifting balance from stress to relaxation response \(\rightarrow\) to build and repair in face of degeneration and destruction; to fight aging and disease;
  - benefits on mood, energy, outlook, and sleep
- Emphasize this as a necessary foundation of treatment plan; and potential “synergy” with pharmacological approaches and genetic resilience factors
Be Proactive to Prevent, Diagnose and Treat Underlying Conditions that Exacerbate Dementia Symptoms

- Be Proactive: Prevent, detect/diagnose and treat underlying medical and psychiatric/psychological/emotional conditions that can exacerbate dementia symptoms, including:
  - dehydration
  - sleep problems/dysregulation
  - obstructive sleep apnea
  - pain
  - constipation
  - infections
  - electrolyte and metabolic derangements
  - anxiety*
  - depression*
  - psychosis*
  - fear*

* e.g. from loss of independence; lack of understanding, connection or stimulation; boredom
Helping Caregivers/Care Partners Cope: Educate, Empower and Support

- Education regarding disease, illness, strategies, planning and to develop a support network
- Calm, structured home environment with limited choices and predictable routine
- Common sense problem solving
- Match activities to abilities and preferences – use “just right activities” to avoid under/overstimulation
- Avoid arguing and overwhelming situations
- Driving and home safety
- Care for the Caregivers – empower them to prioritize self-care as a necessary part of a long journey
Non-pharmacological Interventions & Behavioral Approaches:

- Psycho-education including:
  
  - AD dementia in general and effects on cognition, function and behaviors (heterogeneous, dynamic – fluctuations, lower reserve and non-linear)
  
  - Dementia stage and care expectations; avoid expectation-reality mismatch and miscommunication
  
  - The “progression and regression model of aging and dementia”
  
  - Learning a “new language” and approach to interact and communicate
NonPharmacological Interventions and Behavioral Approaches

Utilizing strategies such as:

- **Stay positive, interact calmly, and be reassuring** – practice empathy, reminding yourself that “It’s the disease (it’s not intentional)”

- **Redirection to pleasurable activities and environment** → focus on fun and maintaining sense of usefulness/worth

- **“Talk deliberately, slowly and keep it simple”: Provide only necessary information in a manner that the patient can now appreciate** → in simple language and small chunks and at the appropriate time

- Under certain conditions an consider compassionate “benign therapeutic fibbing” to avoid unnecessary repeated distress and trauma

- **“Never saying No” to “allow the moment to pass”** → Don’t correct, confront, or convince → Let it go and let it pass (unless there is dire immediate safety issue involved)
• **Describe** a behavior that challenges; who, what, where, when, and how the behavior occurs

• **Investigate** thinking like a detective and explore the person with dementia, the caregivers, and environment for possible clues to triggers underlying possible causes of behavior

• **Create** a prescription in collaboration with your team to help prevent and manage behaviors

• **Evaluate** and review prescription effectiveness, and modify or restart the process as needed

Courtesy of Dr. Helen Kales
Sleep-wake dysregulation: evidence-based opinion

- Apathy and lack of stimulation – fragmented and poor quality sleep → vicious cycle of sleeping/napping several times during the day and poor night-time sleep

- Consider non-pharmacological strategies first; educate & support caregivers

- **Sleep hygiene**: physical, mental, social activity, and stimulation during the day; Avoid PM caffeine (and nicotine)

- Reduce naps to one 1-1.5 hour scheduled nap

- Avoid late and large meals, cool bedroom, no TV late

- Give ChEI in AM

- Consider sleep study (and OSA)

- **If refractory**: **melatonin** (2-3 mg one hr before bedtime → if insufficient increase dose 5-6 mg → 9-10 mg)

- In select cases consider low-dose trazadone (25-50 mg), zolpidem, mirtazapine, quetiapine, …
Wandering: evidence-based opinion

- Can be very disturbing and dangerous
  - **Do root cause analysis:** is it anxiety, confusion, lack of stimulation and engagement (physical, social, mental), medication side effect?
  - Behavioral and environmental strategies → meds unlikely to have favorable risk-benefit profile (due to oversedation, risk of falls)
  - Provide **engagement and stimulation, and EXERCISE**
  - Provide **safe enclosed area to roam** (fenced backyard, corridors w/o access to outside)
  - Door locks and alarms that patients cannot disengage easily
  - Disguise exits
  - Provide **medical ID bracelet**, GPS, and register w/ safety program (e.g. Alz Assoc Safe Return Program)

Abnormal eating behavior: evidence-based opinion

- Eating changes common – under or overeating, eating inappropriately; craving for sweets, hyperorality, poor impulse control

- **Disturbing, dangerous (malnutrition, dehydration)**

- Root cause analysis

- **Consider that the problem can be caused by medications** (wt gain: antipsychotics, TCA, SSRI, mirtazipine, gabapentin, VPA; wt loss: stimulants), endocrine issues (thyroid, diabetes), depression (→ treat)

- If compulsive eating: restrict access to food, lock on refrigerators and cabinets, buy small quantities; if refractory consider trial of SSRI or carbamazepine

- **Under eating: provide favorite foods (often from childhood), engagement and social eating, small portions (replenished) on large plate, soft music in background**

- If refractory: consider mirtazipine (esp. if sleep or depression co-occurring), quetiapine (if severely agitated), megestrol, dronabinol.

Incontinence: evidence-based opinion

- Very challenging
  - Root cause analysis
  - Consider medical causes (e.g. UTI)
  - Restrict caffeine, consider ChEI dose or timing
  - Schedule intake and bathroom visits
  - Adult diapers
  - Bedside commode
  - Pelvic floor exercises (need more intact cognition)
  - Pessary

- Most medications for incontinence are anticholinergic – if have to may consider long acting trospium

Conclusions

“Where there is no hope, there can be no endeavour” ~ Samuel Johnson

“The journey of a thousand miles begins with one step” ~ Lau Tzu

THANK YOU!

... the glass is more than half full!