The Neuropsychiatric Symptoms of Dementia:

A Visual Guide to Response Considerations

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About the Guide:

This guide is a product of the collective experiences of those who have contributed to and reviewed this tool. It does not, nor could it, include all possible considerations or interventions needed to help a person with dementia. Each person with dementia brings their own history, personality, medical conditions, family, coping styles and many other issues that require attention, analysis and commitment in order to support quality of life through the disease process.

Following general definitions and information about the neuropsychiatric symptoms of dementia, subsequent sections will direct you to specific considerations. It is hoped that this guide will offer ideas and conversations to help people with dementia.

Contents:

About Dementia:

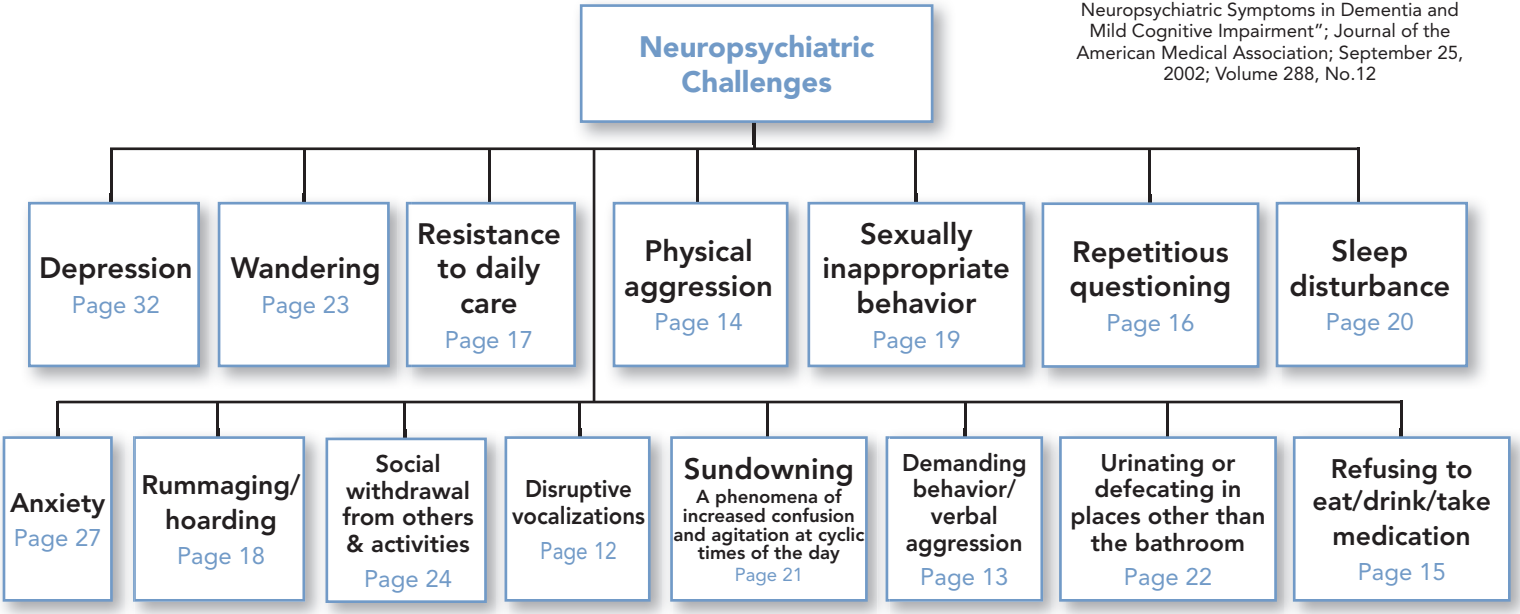
The term "dementia" simply means that a progressive neurological disease is present. There are many types of dementia. Alzheimer's disease is the most common type. While the dementias may present with some common symptoms and may result in the same conclusion, how each of these diseases move through the brain can be different and requires caregivers to be informed in the unique type of dementia present. Informed and prepared caregivers often result in reduction or avoidance of foreseeable crisis. A thorough dementia evaluation can assist in not only narrowing the type of dementia, but also preparing individuals and families in how to live with disease. It includes a brain scan, blood work, lab work, cognitive testing and a complete clinical history. Physicians may order additional tests as well. While affective and behavioral symptoms, especially depression, can occur at any time depending on the medical and environmental context, the highest risk for the neuropsychiatric symptoms occurs in the middle stages of the disease and beyond.

Section I

General Behavior Information

"80% of individuals with a dementia will experience neuropsychiatric (behavioral and affective) symptoms. The many serious consequences of these complications are greater impairment in activities of daily living, more rapid cognitive decline, worse quality of life, earlier institutionalization and greater caregiver depression."[1]

[1] Lyketos, C., Lopez, O., Jones, B., Fitzpatrick, A., Breitner, J., DeKosky, S.; "Prevalence of Neuropsychiatric Symptoms in Dementia and Mild Cognitive Impairment"; Journal of the American Medical Association; September 25, 2002; Volume 288, No.12



Disease Vulnerabilities to Behavioral and Affective Challenges

While the disease exposes risk to these challenges, when they occur, it is never the case that we terminate further exploration and understanding simply because they have the disease. Instead, caregivers and clinicians must heighten their calculations of possible contributing factors and interventions. That is an important part of supporting quality of life.

Visual spatial deficits
Depth perception can be affected very early on in the disease. In middle stage, it can interfere with a sense of where one is in relationship to others.

Damage to executive functions
Logic, cognitive flexibility (ability to shift from one topic or activity to another), judgment, insight, decision-making, interpreting social cues.

Damage to the "filter"
Related to declines in executive functions, the "filter" between thought and action breaks down and people may say or do whatever comes into their mind.

Damage to communication centers
Word finding, word substitution and following a train of thought becomes increasingly challenging as does understanding the words spoken by others.

Decreasing access to historical coping strategies
Everyone has coping patterns, whether it be sitting quietly alone, reaching out to friends, work, etc. Many individuals in the middle and later stages of Alzheimer's disease do not have access to those strategies that have helped them cope with difficulties.

Damage to the sleep/wake regulator of the brain

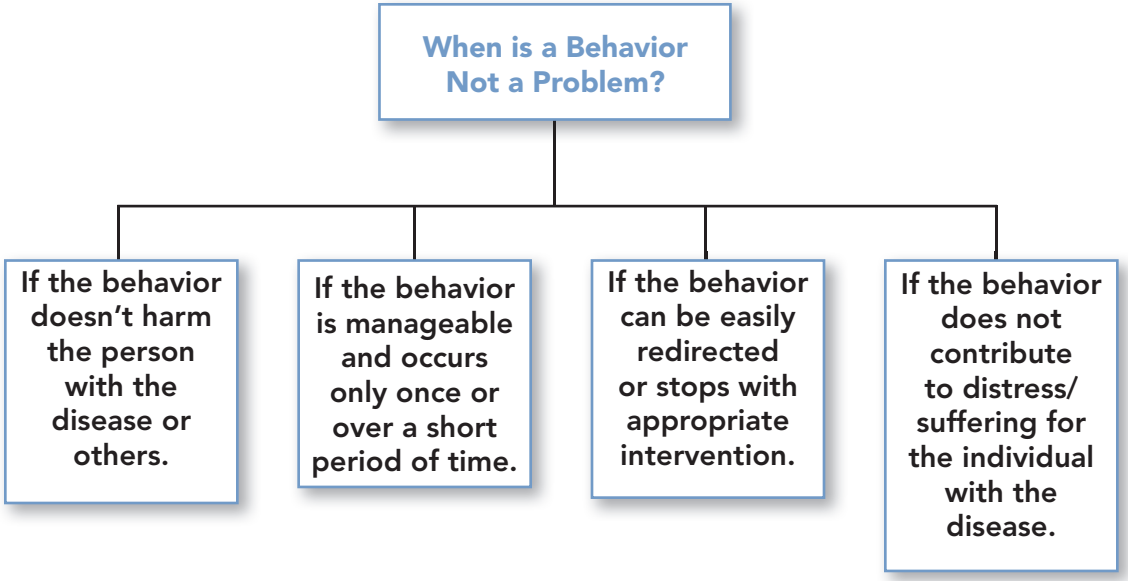
Loss of directional map
The disease damages the part of the brain that helps one find their way around.

Loss of noise filter
Noises are not prioritized. Multiple noises meld together and can be distracting and distressing.

Inability to multi-task
Alzheimer's limits the mind's ability to attend to more than one thing at a time.

Damage to short-term memory
Short-term memory is primarily found in one area of the brain. It is the area the disease attacks early on and is progressively impacted. Long-term memory, which is dispersed all over our brain, is preserved through a significant part of the disease.

Damage to emotional center
Individuals with Alzheimer's are at high risk for depression, as well as mood instability unrelated to depression. Individuals therefore have a lower threshold for becoming frustrated.



Affective and behavioral symptoms are problematic when they interfere in quality of life, including ability to absorb enjoyable elements around them, to receive care, and to utilize the strengths and abilities that they continue to possess.

Medications

While environmental interventions and therapeutic care may reduce or negate the need for pharmacological intervention, there are times incorporating medication as part of a treatment plan for individuals going through behavioral and affective challenges is necessary. It is important to understand general types of medications utilized in order to avoid an automatic default to anti-psychotics and anxiolytics. There may be circumstances where an individual's medical status or long-term belief system precludes incorporation of pharmacological interventions. Further, all medications carry with them potential side effects. Dialogue with families about risk/benefit profile should occur around the use of any medication. When prescribing such medication, those with less potent side effects should be attempted first; often that means antidepressant trial. Careful assessment of these drugs is always important. At times, primary physicians may prescribe such medications. However, in situations where multiple psychotropic medications are on board, intolerable side effects occur, or challenging behavior persists, securing opinion from a geriatric psychiatrist may be indicated. Further, medication response may change or decline over time necessitating re-evaluation of medications. The need for medications should be reevaluated on an ongoing basis.

Types of psychotropic medications include:

- ***Antidepressants***
  Antidepressants target the set of symptoms that constitute depression — such as irritability, negativity, anxiety, resistance, agitation, sadness, sleep disturbance, expressions of worthlessness/desire to die, and appetite changes. Symptoms of depression can even include paranoia and other forms of psychosis.

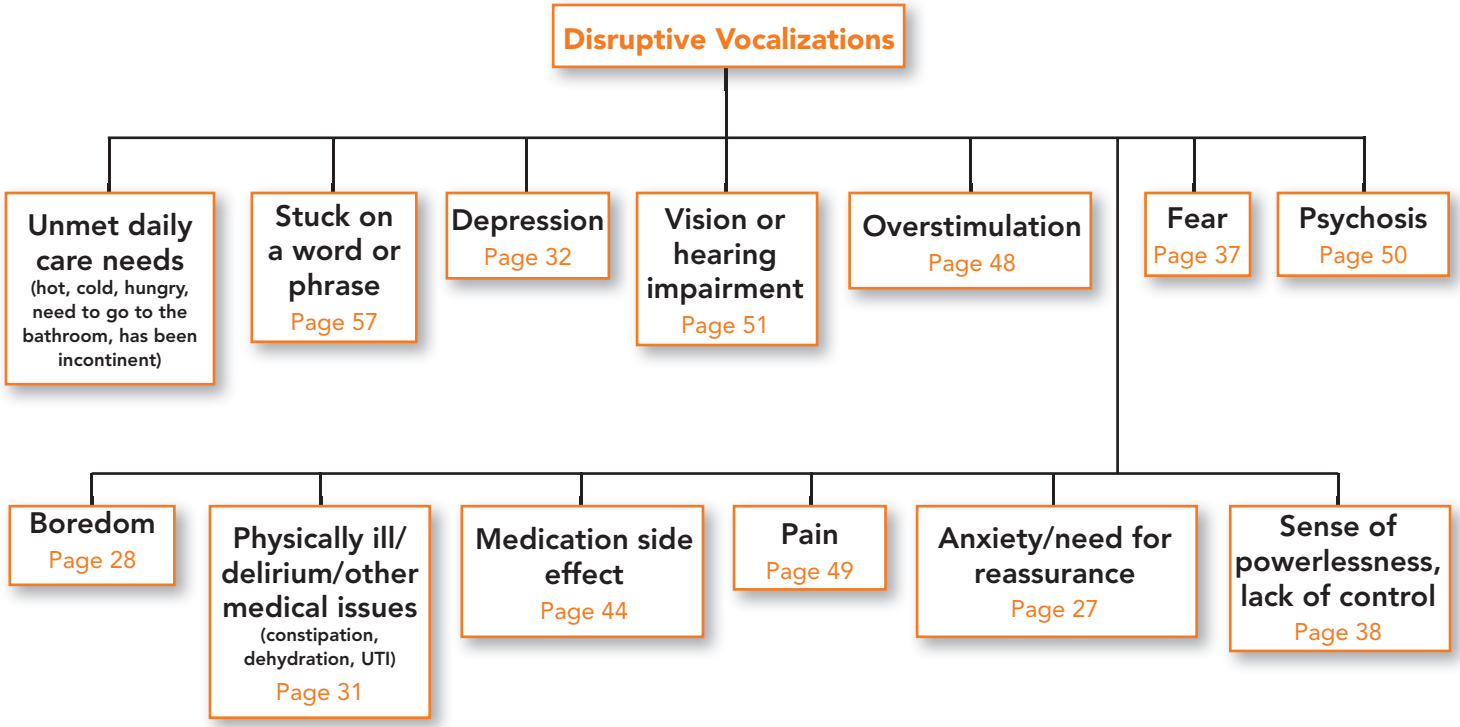
- ***Mood Stabilizers***
  Mood stabilizers, such as Depakote and Neurontin, are given in this population to assist in management of agitation and aggression. While evidence regarding the significance of their benefit is lacking, their use is often associated with attempts to minimize or avoid use of the antipsychotic medication.

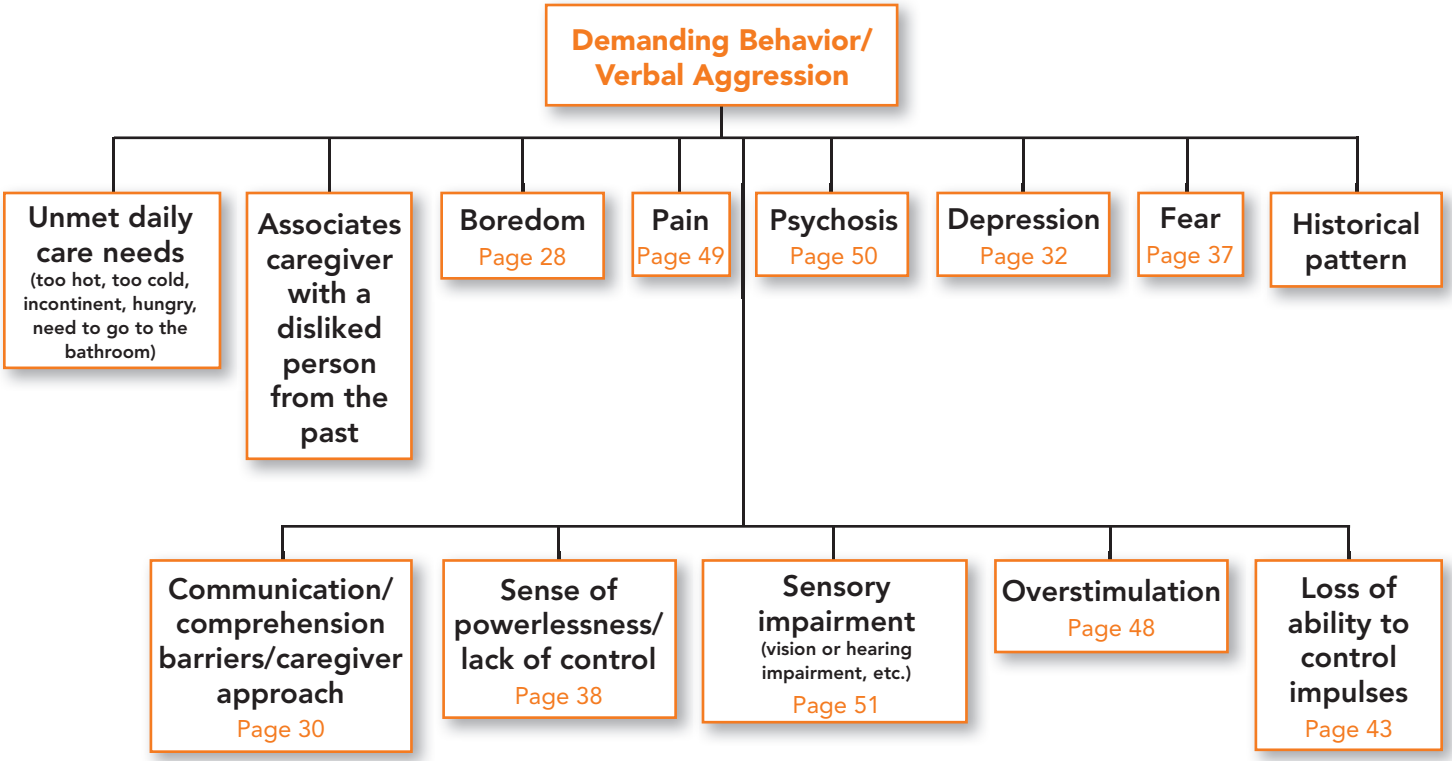
- ***Anti-anxiety Agents***
  Anti – anxiety agents may be indicated in short-term crisis situations, in individuals who have had struggled with long standing generalized anxiety disorders in their life prior to dementia, end of life situations and in people with Parkinson's disease or other movement disorders. They can provoke paradoxical effects, increase fall risk, increase confusion, and negatively impact function.
- ***Anti-psychotic Medications***
  The newer anti-psychotic medications such as Risperidol, Zyprexa and Seroquel may be utilized as part of the treatment for the behavioral consequences of dementia. While their use may be unavoidable, all other possible interventions should be attempted first in order to minimize or negate use of this class of medications. They do have serious potential side effects including increased risk of death and, as with any medication, risk/benefit profile should be discussed with family.

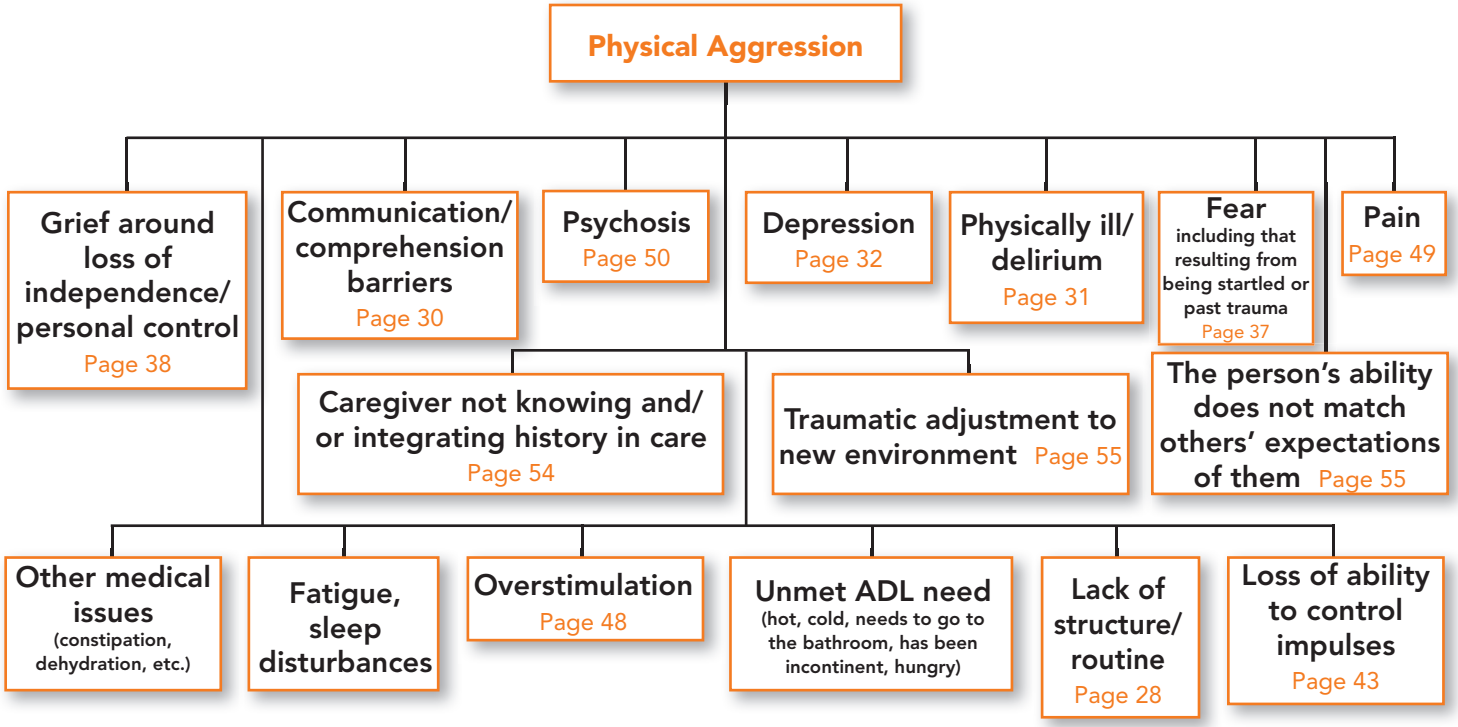
Careful monitoring of these medications is always necessary. They often require titration, many require withdrawal protocol, and they may or may not be required for extended amounts of time. Medication should not be used as a substitute for good care, for activity or for medical assessment, nor is the goal sedation. Decisions to incorporate such medication are based in the commitment to reduce suffering and improve quality of life. Incorporation of appropriate medication may extend the family's ability to care for the person at home, may reduce safety risks to the person and others and may prevent premature disability.

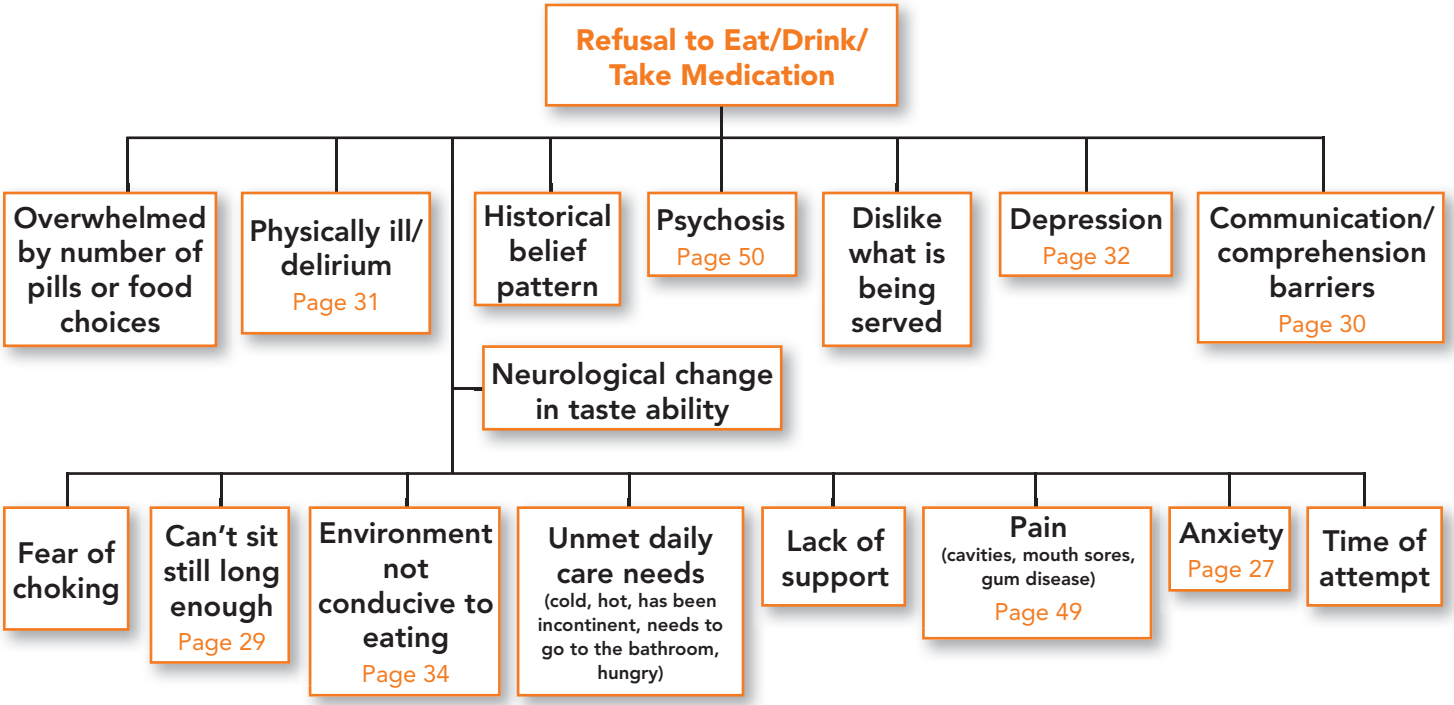
Section II

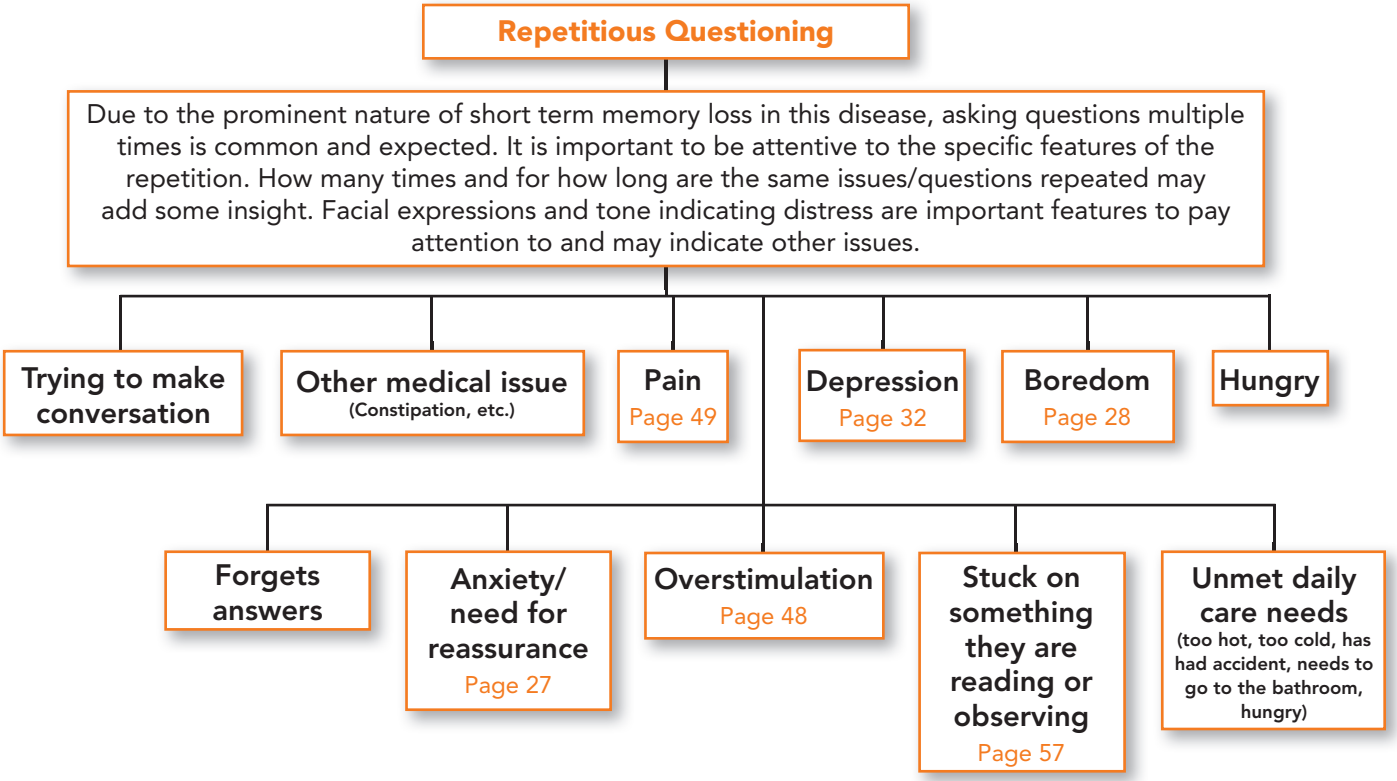
Possible Reasons for Specific Neuropsychiatric Challenges

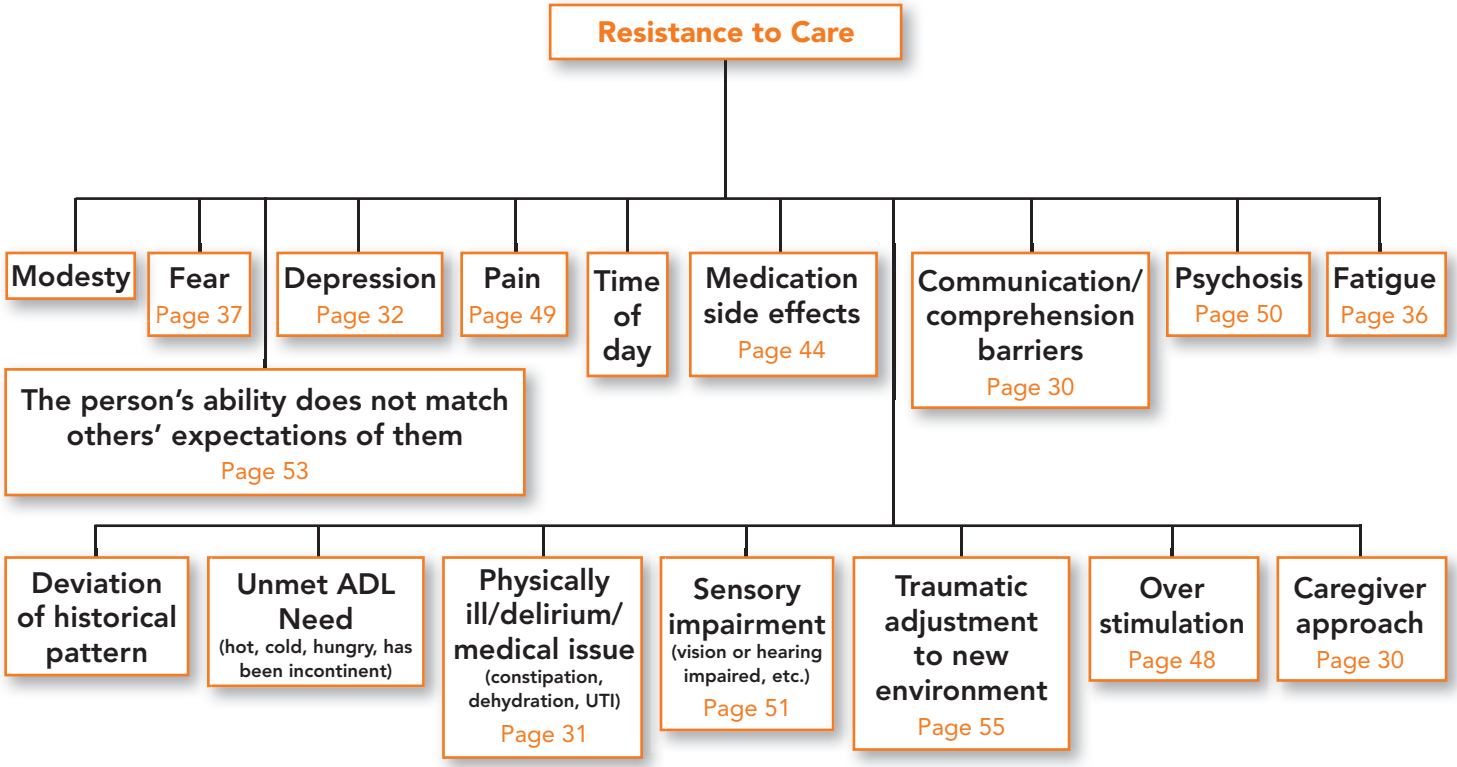

Disruptive Vocalizations
Unmet daily care needs
(hot, cold, hungry, need to go to the bathroom, has been incontinent)
Stuck on a word or phrase
Page 57
Depression
Page 32
Vision or hearing impairment
Page 51
Overstimulation
Page 48
Fear
Page 37
Psychosis
Page 50
Boredom
Page 28
Physically ill/ delirium/other medical issues
(constipation, dehydration, UTI)
Page 31
Medication side effect
Page 44
Pain
Page 49
Anxiety/need for reassurance
Page 27
Sense of powerlessness, lack of control
Page 38

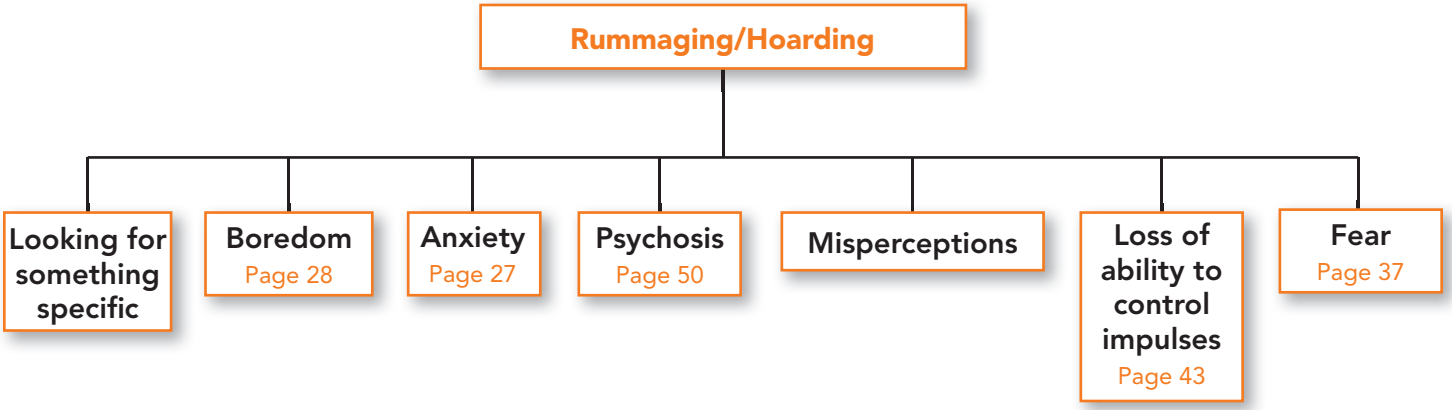

Demanding Behavior/ Verbal Aggression
Unmet daily care needs (too hot, too cold, incontinent, hungry, need to go to the bathroom)
Associates caregiver with a disliked person from the past
Boredom Page 28
Pain Page 49
Psychosis Page 50
Depression Page 32
Fear Page 37
Historical pattern
Communication/ comprehension barriers/caregiver approach Page 30
Sense of powerlessness/ lack of control Page 38
Sensory impairment (vision or hearing impairment, etc.) Page 51
Overstimulation Page 48
Loss of ability to control impulses Page 43

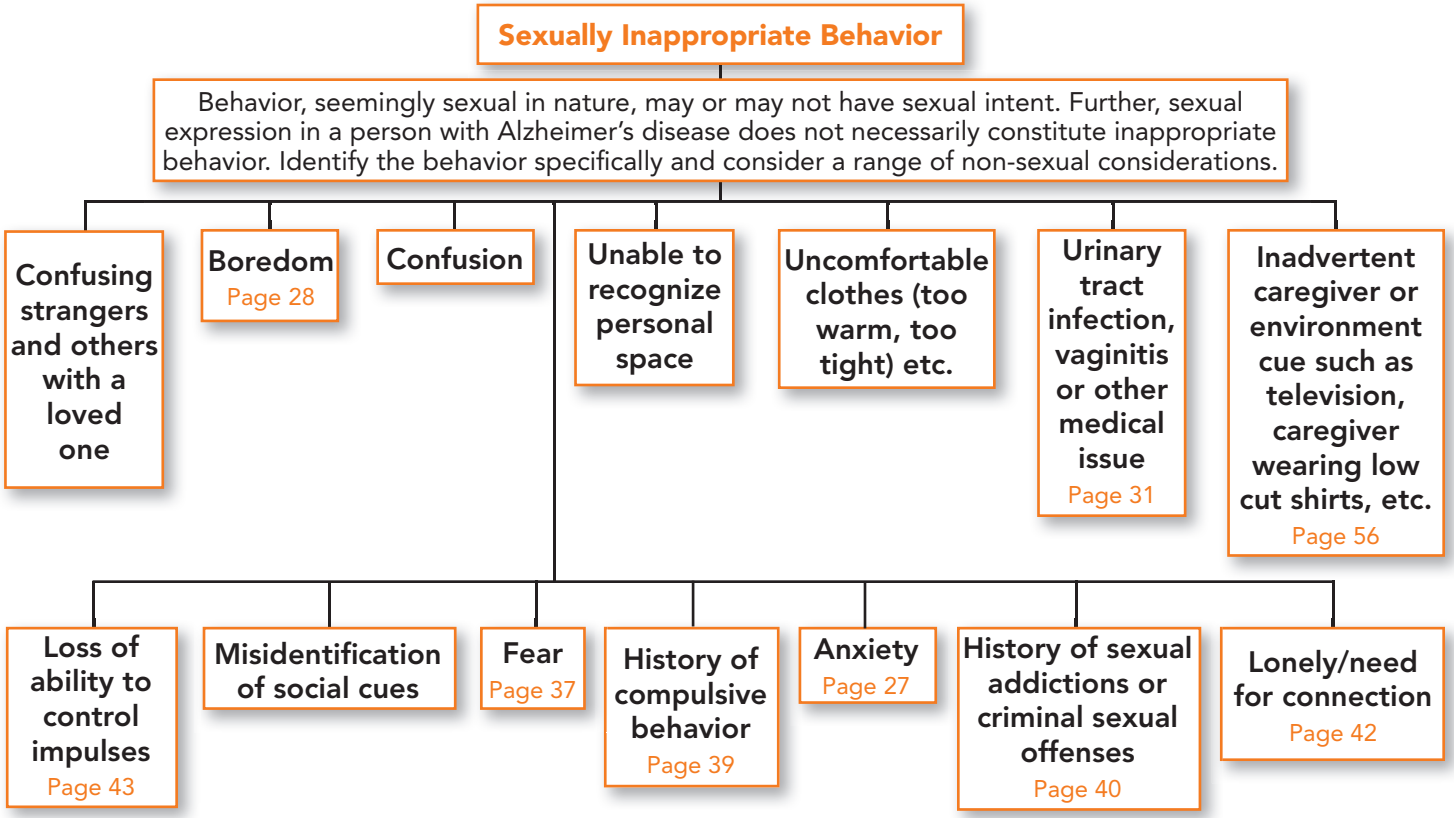

Physical Aggression
Grief around loss of independence/ personal control
Page 38
Communication/ comprehension barriers
Page 30
Psychosis
Page 50
Depression
Page 32
Physically ill/ delirium
Page 31
Fear
including that resulting from being startled or past trauma
Page 37
Pain
Page 49
Caregiver not knowing and/ or integrating history in care
Page 54
Traumatic adjustment to new environment
Page 55
The person's ability does not match others' expectations of them
Page 55
Other medical issues
(constipation, dehydration, etc.)
Fatigue, sleep disturbances
Overstimulation
Page 48
Unmet ADL need
(hot, cold, needs to go to the bathroom, has been incontinent, hungry)
Lack of structure/ routine
Page 28
Loss of ability to control impulses
Page 43

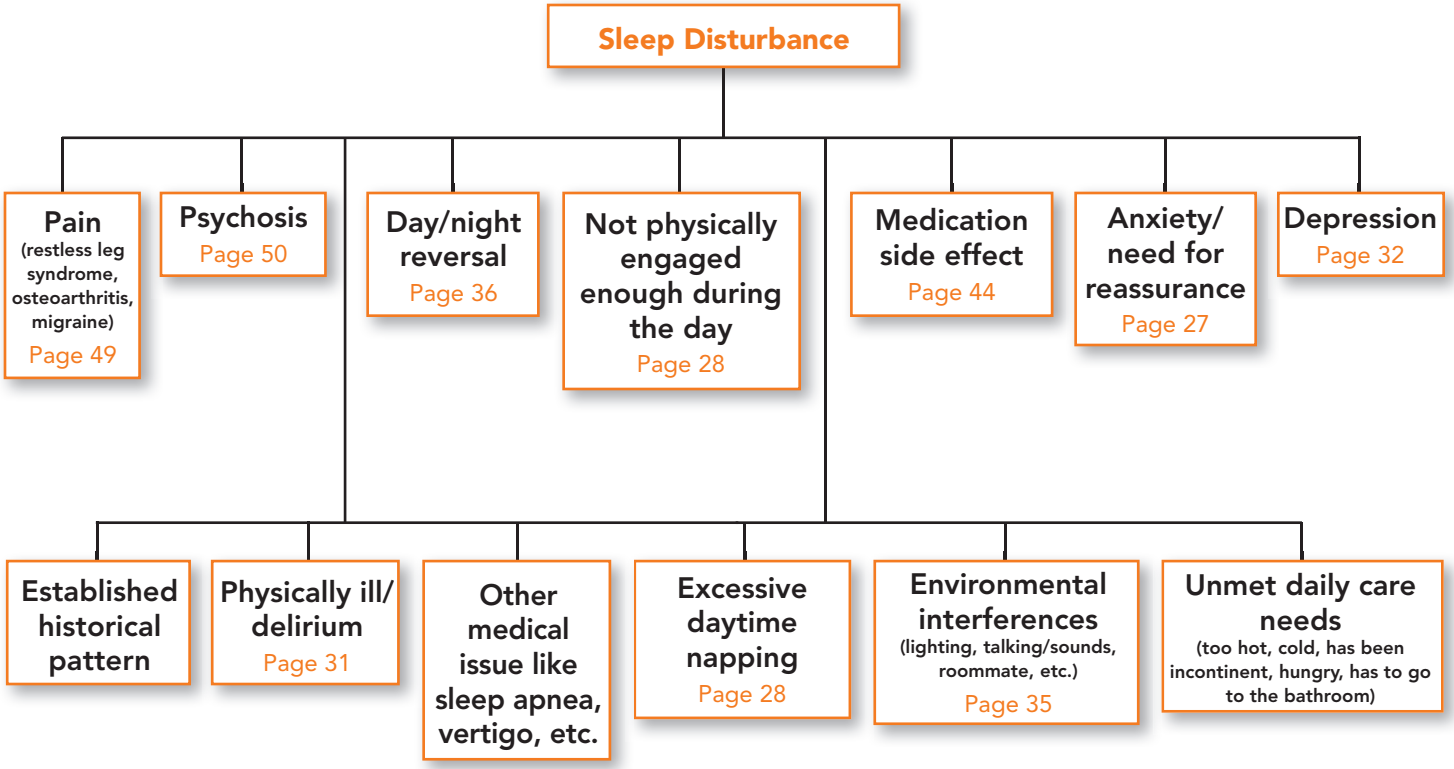

Refusal to Eat/Drink/ Take Medication
Overwhelmed by number of pills or food choices
Physically ill/ delirium
Page 31
Historical belief pattern
Psychosis
Page 50
Dislike what is being served
Depression
Page 32
Communication/ comprehension barriers
Page 30
Neurological change in taste ability
Fear of choking
Can't sit still long enough
Page 29
Environment not conducive to eating
Page 34
Unmet daily care needs
(cold, hot, has been incontinent, needs to go to the bathroom, hungry)
Lack of support
Pain
(cavities, mouth sores, gum disease)
Page 49
Anxiety
Page 27
Time of attempt

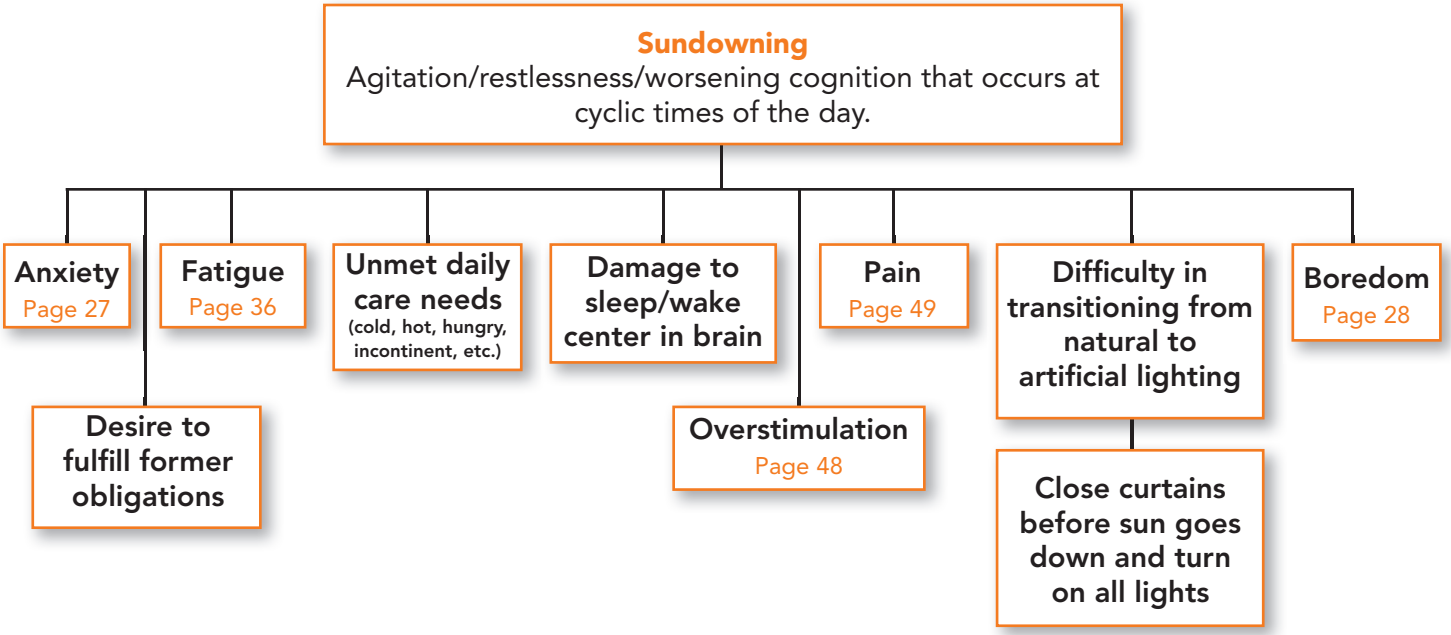

Repetitious Questioning
Due to the prominent nature of short term memory loss in this disease, asking questions multiple times is common and expected. It is important to be attentive to the specific features of the repetition. How many times and for how long are the same issues/questions repeated may add some insight. Facial expressions and tone indicating distress are important features to pay attention to and may indicate other issues.
Trying to make conversation
Other medical issue (Constipation, etc.)
Pain Page 49
Depression Page 32
Boredom Page 28
Hungry
Forgets answers
Anxiety/ need for reassurance Page 27
Overstimulation Page 48
Stuck on something they are reading or observing Page 57
Unmet daily care needs (too hot, too cold, has had accident, needs to go to the bathroom, hungry)

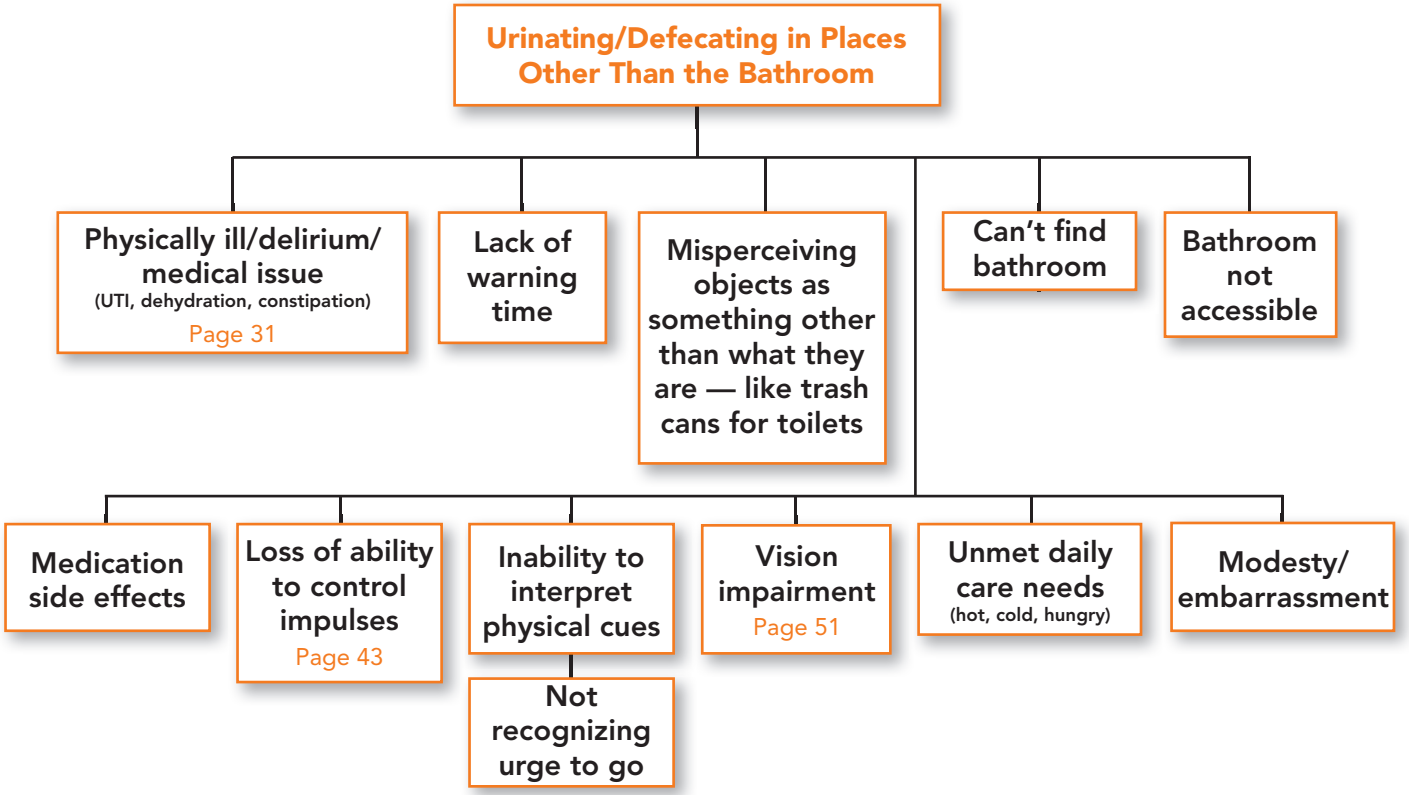

Resistance to Care
Modesty
Fear
Page 37
Depression
Page 32
Pain
Page 49
Time of day
Medication side effects
Page 44
Communication/ comprehension barriers
Page 30
Psychosis
Page 50
Fatigue
Page 36
The person's ability does not match others' expectations of them
Page 53
Deviation of historical pattern
Unmet ADL Need
(hot, cold, hungry, has been incontinent)
Physically ill/delirium/ medical issue
(constipation, dehydration, UTI)
Page 31
Sensory impairment
(vision or hearing impaired, etc.)
Page 51
Traumatic adjustment to new environment
Page 55
Over stimulation
Page 48
Caregiver approach
Page 30

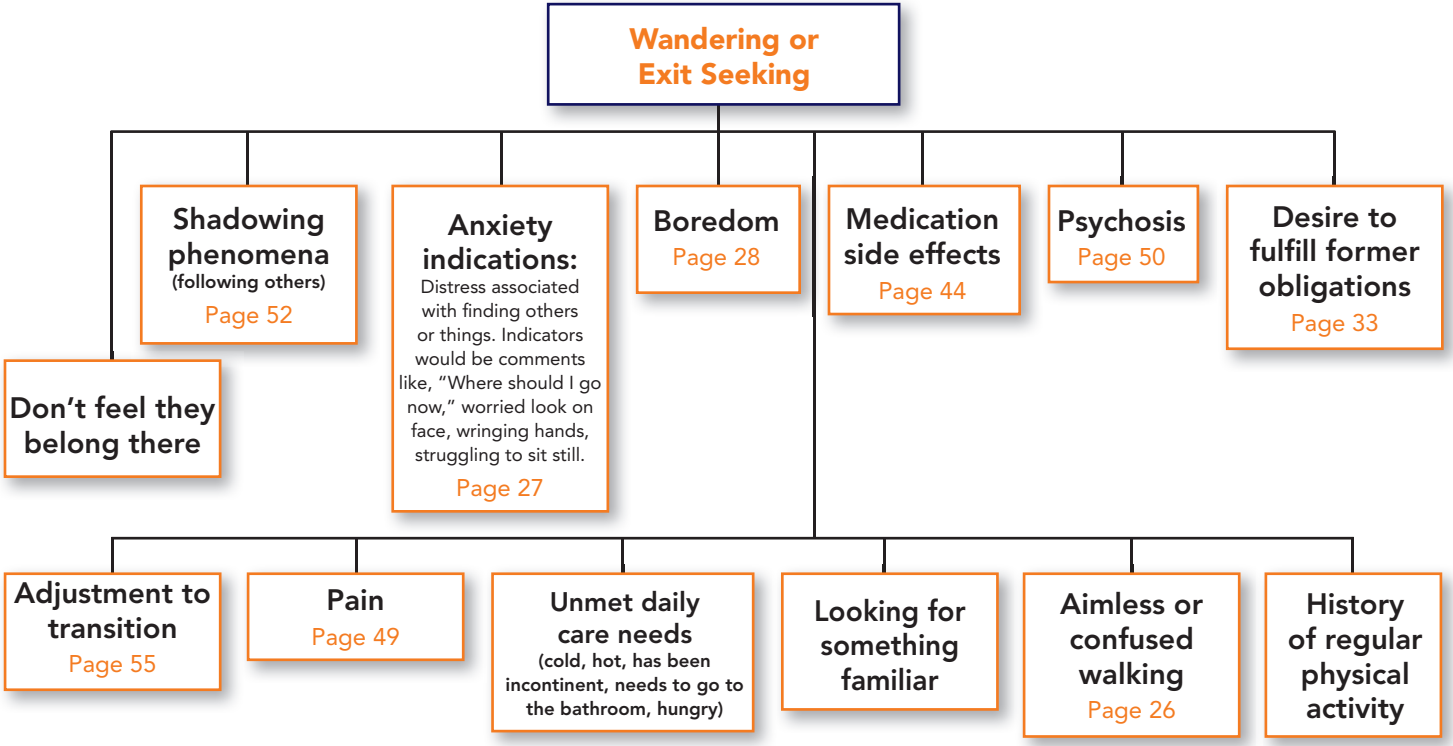

Rummaging/Hoarding
Looking for something specific
Boredom
Page 28
Anxiety
Page 27
Psychosis
Page 50
Misperceptions
Loss of ability to control impulses
Page 43
Fear
Page 37

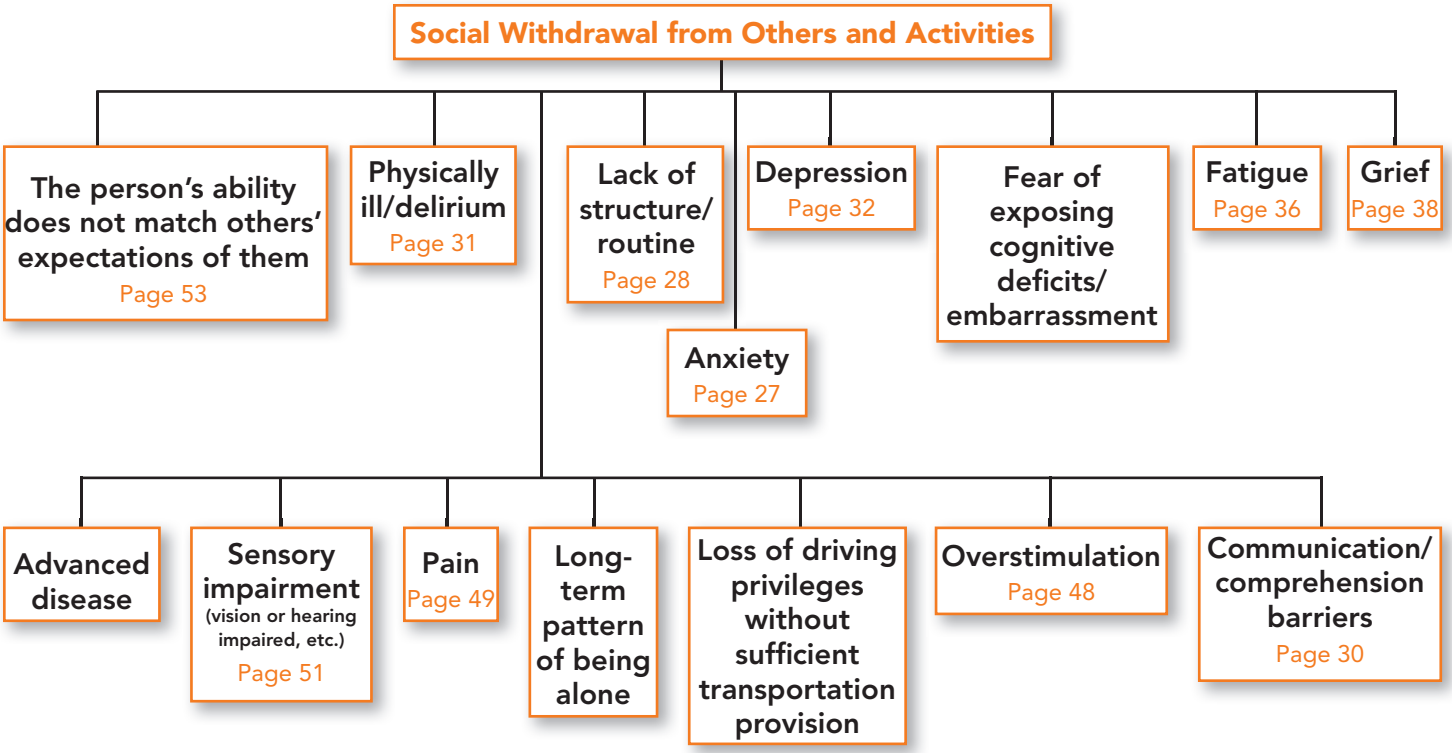

Sexually Inappropriate Behavior
Behavior, seemingly sexual in nature, may or may not have sexual intent. Further, sexual expression in a person with Alzheimer's disease does not necessarily constitute inappropriate behavior. Identify the behavior specifically and consider a range of non-sexual considerations.
Confusing strangers and others with a loved one
Boredom
Page 28
Confusion
Unable to recognize personal space
Uncomfortable clothes (too warm, too tight) etc.
Urinary tract infection, vaginitis or other medical issue
Page 31
Inadvertent caregiver or environment cue such as television, caregiver wearing low cut shirts, etc.
Page 56
Loss of ability to control impulses
Page 43
Misidentification of social cues
Fear
Page 37
History of compulsive behavior
Page 39
Anxiety
Page 27
History of sexual addictions or criminal sexual offenses
Page 40
Lonely/need for connection
Page 42


Sleep Disturbance
Pain
(restless leg syndrome, osteoarthritis, migraine)
Page 49
Psychosis
Page 50
Day/night reversal
Page 36
Not physically engaged enough during the day
Page 28
Medication side effect
Page 44
Anxiety/ need for reassurance
Page 27
Depression
Page 32
Established historical pattern
Physically ill/ delirium
Page 31
Other medical issue like sleep apnea, vertigo, etc.
Excessive daytime napping
Page 28
Environmental interferences
(lighting, talking/sounds, roommate, etc.)
Page 35
Unmet daily care needs
(too hot, cold, has been incontinent, hungry, has to go to the bathroom)


Sundowning
Agitation/restlessness/worsening cognition that occurs at cyclic times of the day.
Anxiety
Page 27
Fatigue
Page 36
Unmet daily care needs
(cold, hot, hungry, incontinent, etc.)
Damage to sleep/wake center in brain
Pain
Page 49
Difficulty in transitioning from natural to artificial lighting
Boredom
Page 28
Desire to fulfill former obligations
Overstimulation
Page 48
Close curtains before sun goes down and turn on all lights


Urinating/Defecating in Places Other Than the Bathroom
Physically ill/delirium/ medical issue
(UTI, dehydration, constipation)
Page 31
Lack of warning time
Misperceiving objects as something other than what they are — like trash cans for toilets
Can't find bathroom
Bathroom not accessible
Medication side effects
Loss of ability to control impulses
Page 43
Inability to interpret physical cues
Not recognizing urge to go
Vision impairment
Page 51
Unmet daily care needs
(hot, cold, hungry)
Modesty/ embarrassment

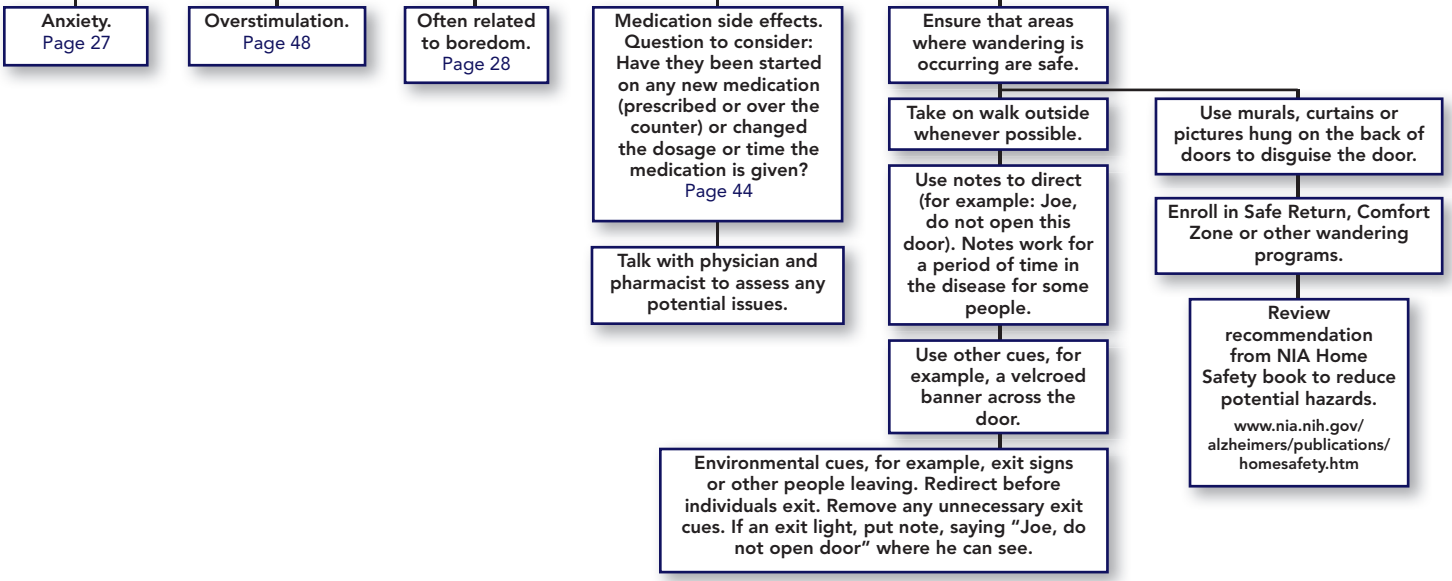

Wandering or Exit Seeking
Shadowing phenomena (following others) Page 52
Anxiety indications: Distress associated with finding others or things. Indicators would be comments like, "Where should I go now," worried look on face, wringing hands, struggling to sit still. Page 27
Boredom Page 28
Medication side effects Page 44
Psychosis Page 50
Desire to fulfill former obligations Page 33
Don't feel they belong there
Adjustment to transition Page 55
Pain Page 49
Unmet daily care needs (cold, hot, has been incontinent, needs to go to the bathroom, hungry)
Looking for something familiar
Aimless or confused walking Page 26
History of regular physical activity

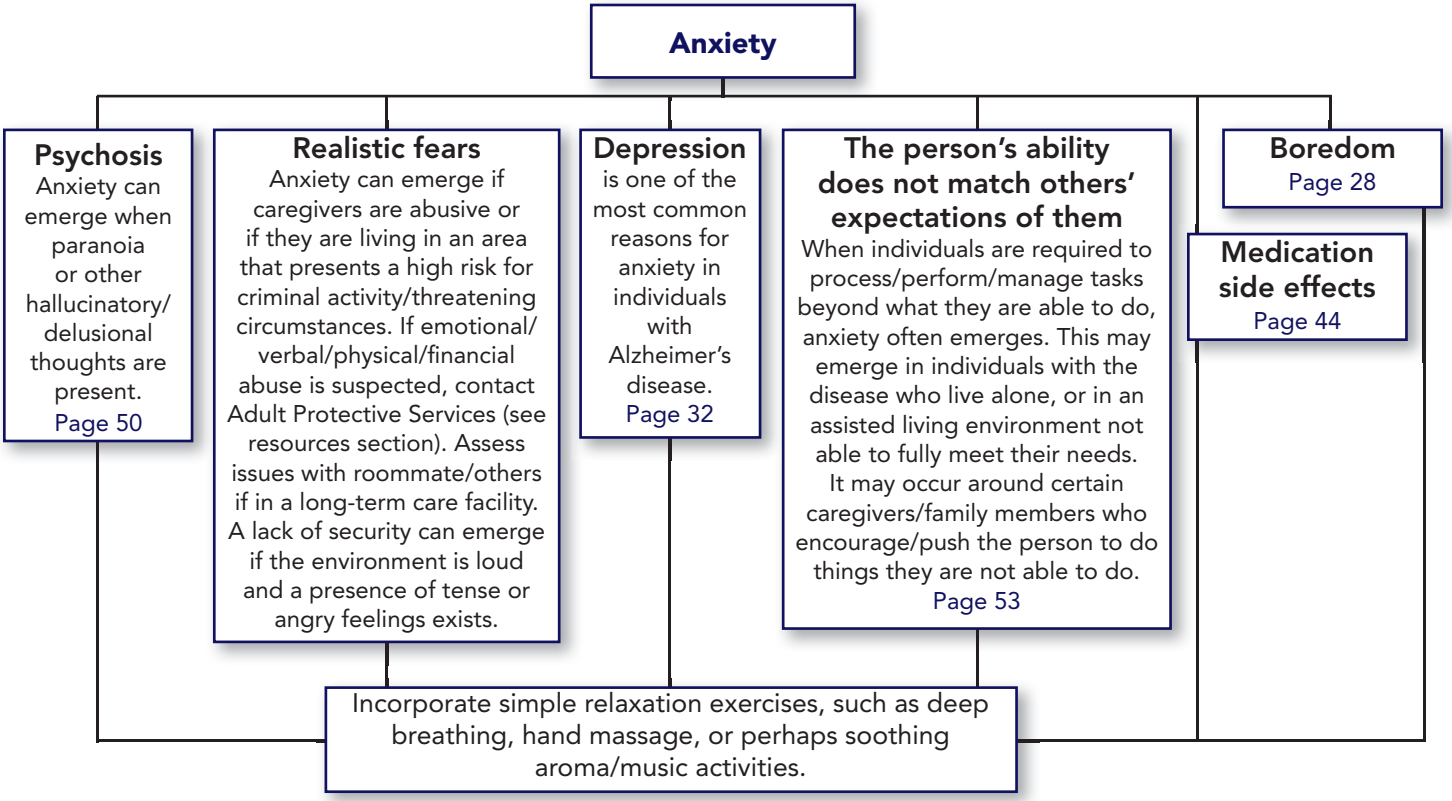

Social Withdrawal from Others and Activities
The person's ability does not match others' expectations of them
Page 53
Physically ill/delirium
Page 31
Lack of structure/ routine
Page 28
Depression
Page 32
Anxiety
Page 27
Fear of exposing cognitive deficits/ embarrassment
Fatigue
Page 36
Grief
Page 38
Advanced disease
Sensory impairment
(vision or hearing impaired, etc.)
Page 51
Pain
Page 49
Long-term pattern of being alone
Loss of driving privileges without sufficient transportation provision
Overstimulation
Page 48
Communication/ comprehension barriers
Page 30

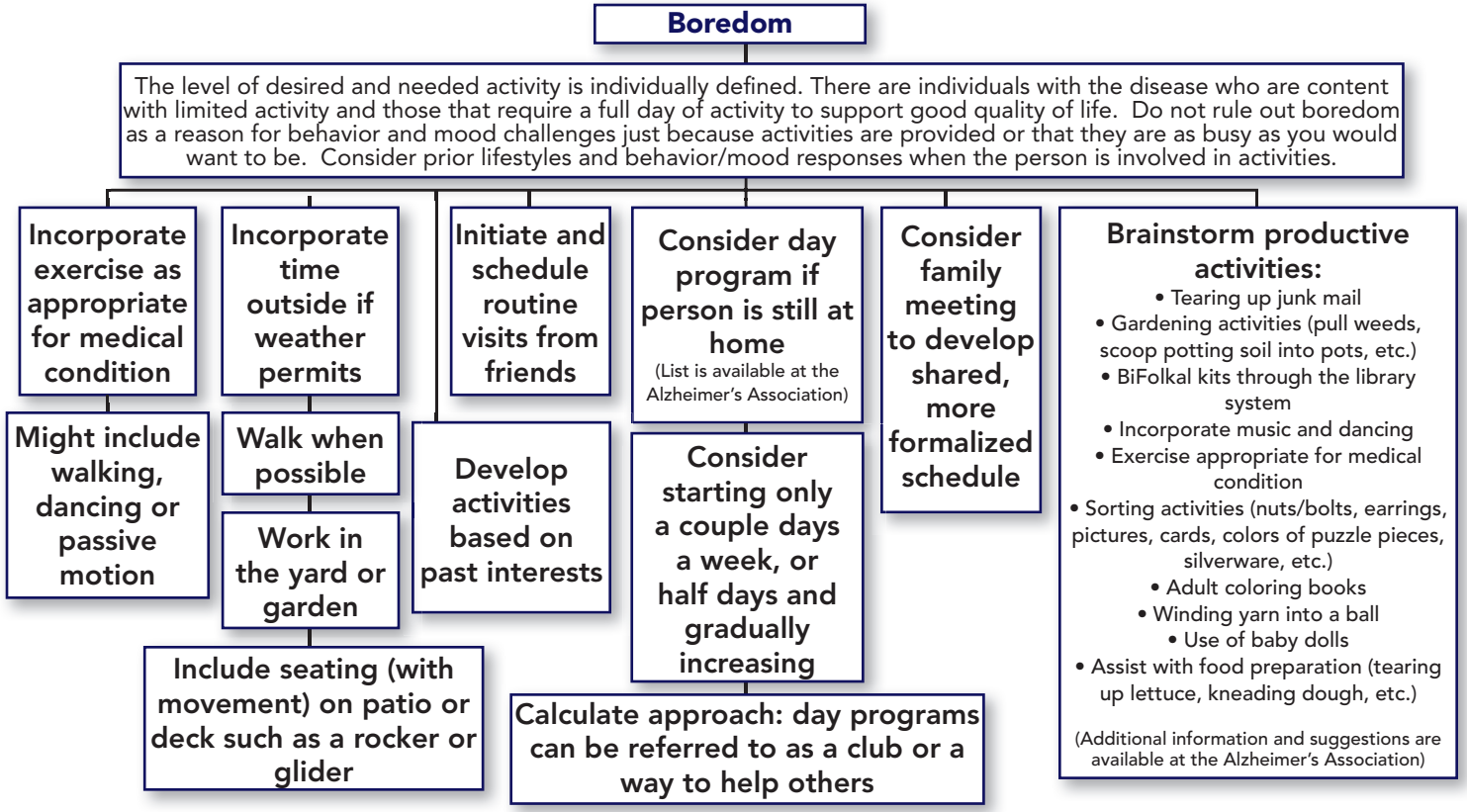
Section III
Interventions

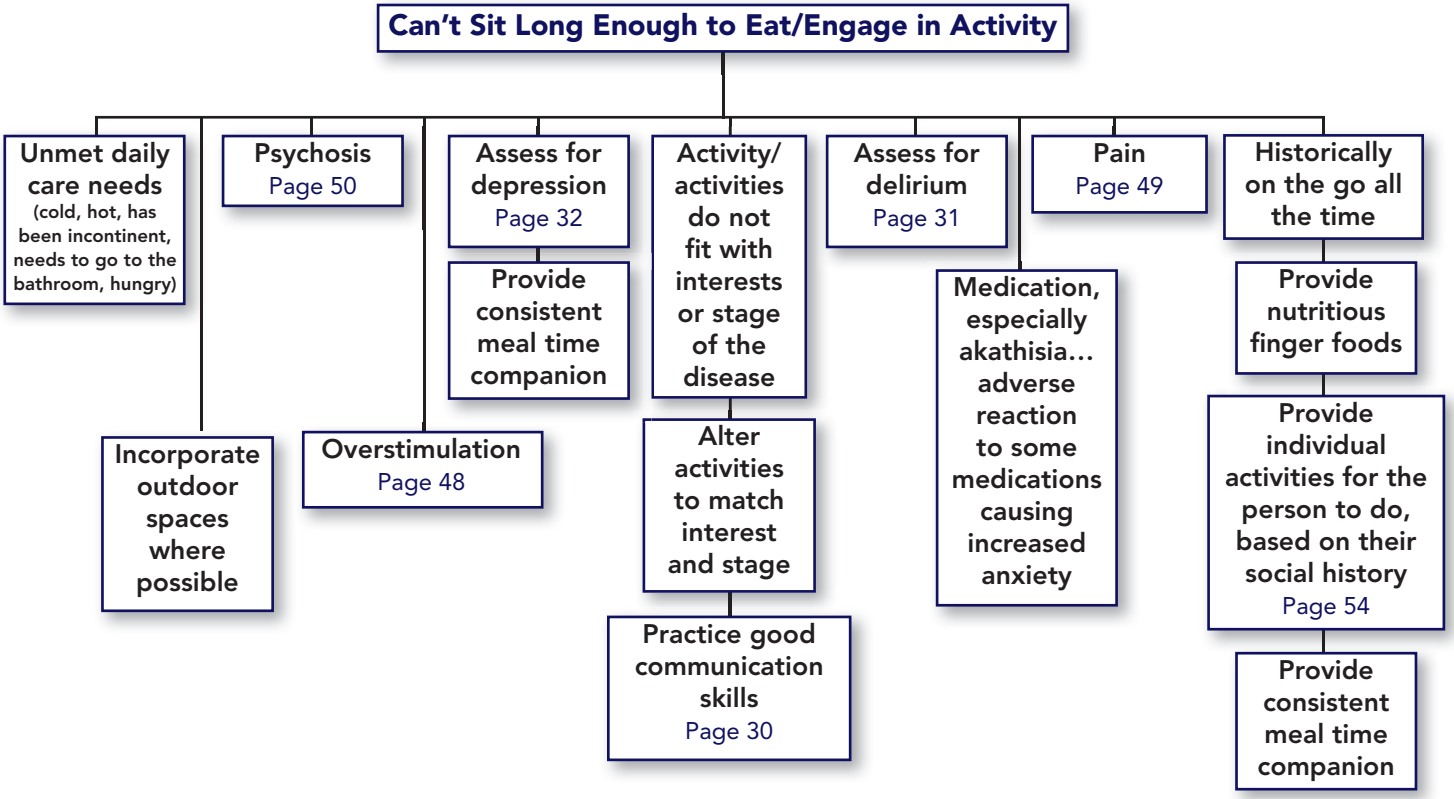
Aimless or Confused Wandering

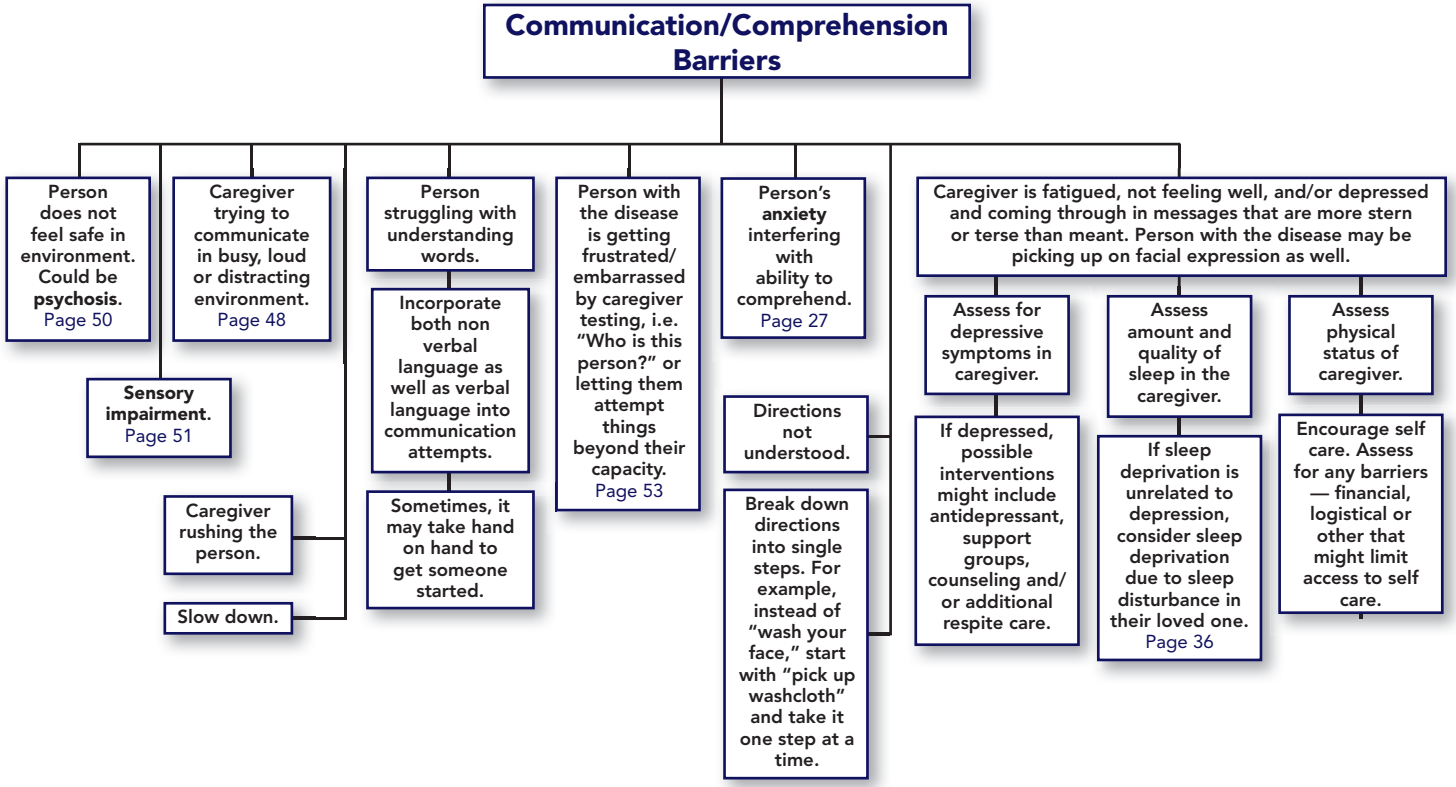
It is generally considered to be a positive for individuals to remain walking through much of the disease. It reduces fall risk, can reduce anxiety, can improve sleep, and represents productive activity. Walking around can provoke some challenges if the person is at home or in an environment that may present elopement risk, however. Aimless walking means that it is not because of psychosis, a search to fulfill previous responsibilities such as searching for mom, or other defined clear explanation.




Anxiety
Psychosis
Anxiety can emerge when paranoia or other hallucinatory/ delusional thoughts are present.
Page 50
Realistic fears
Anxiety can emerge if caregivers are abusive or if they are living in an area that presents a high risk for criminal activity/threatening circumstances. If emotional/ verbal/physical/financial abuse is suspected, contact Adult Protective Services (see resources section). Assess issues with roommate/others if in a long-term care facility. A lack of security can emerge if the environment is loud and a presence of tense or angry feelings exists.
Depression
is one of the most common reasons for anxiety in individuals with Alzheimer's disease.
Page 32
The person's ability does not match others' expectations of them
When individuals are required to process/perform/manage tasks beyond what they are able to do, anxiety often emerges. This may emerge in individuals with the disease who live alone, or in an assisted living environment not able to fully meet their needs. It may occur around certain caregivers/family members who encourage/push the person to do things they are not able to do.
Page 53
Boredom
Page 28
Medication side effects
Page 44
Incorporate simple relaxation exercises, such as deep breathing, hand massage, or perhaps soothing aroma/music activities.


Boredom
The level of desired and needed activity is individually defined. There are individuals with the disease who are content with limited activity and those that require a full day of activity to support good quality of life. Do not rule out boredom as a reason for behavior and mood challenges just because activities are provided or that they are as busy as you would want to be. Consider prior lifestyles and behavior/mood responses when the person is involved in activities.
Incorporate exercise as appropriate for medical condition
Might include walking, dancing or passive motion
Incorporate time outside if weather permits
Walk when possible
Work in the yard or garden
Include seating (with movement) on patio or deck such as a rocker or glider
Initiate and schedule routine visits from friends
Develop activities based on past interests
Consider day program if person is still at home
(List is available at the Alzheimer's Association)
Consider starting only a couple days a week, or half days and gradually increasing
Calculate approach: day programs can be referred to as a club or a way to help others
Consider family meeting to develop shared, more formalized schedule
Brainstorm productive activities:
• Tearing up junk mail
• Gardening activities (pull weeds, scoop potting soil into pots, etc.)
• BiFolkal kits through the library system
• Incorporate music and dancing
• Exercise appropriate for medical condition
• Sorting activities (nuts/bolts, earrings, pictures, cards, colors of puzzle pieces, silverware, etc.)
• Adult coloring books
• Winding yarn into a ball
• Use of baby dolls
• Assist with food preparation (tearing up lettuce, kneading dough, etc.)
(Additional information and suggestions are available at the Alzheimer's Association)


Can't Sit Long Enough to Eat/Engage in Activity
Unmet daily care needs (cold, hot, has been incontinent, needs to go to the bathroom, hungry)
Incorporate outdoor spaces where possible
Psychosis Page 50
Overstimulation Page 48
Assess for depression Page 32
Provide consistent meal time companion
Activity/ activities do not fit with interests or stage of the disease
Alter activities to match interest and stage
Practice good communication skills Page 30
Assess for delirium Page 31
Medication, especially akathisia… adverse reaction to some medications causing increased anxiety
Pain Page 49
Historically on the go all the time
Provide nutritious finger foods
Provide individual activities for the person to do, based on their social history Page 54
Provide consistent meal time companion


Communication/Comprehension Barriers
Person does not feel safe in environment. Could be psychosis. Page 50
Sensory impairment. Page 51
Caregiver trying to communicate in busy, loud or distracting environment. Page 48
Caregiver rushing the person.
Slow down.
Person struggling with understanding words.
Incorporate both non verbal language as well as verbal language into communication attempts.
Sometimes, it may take hand on hand to get someone started.
Person with the disease is getting frustrated/ embarrassed by caregiver testing, i.e. "Who is this person?" or letting them attempt things beyond their capacity. Page 53
Person's anxiety interfering with ability to comprehend. Page 27
Directions not understood.
Break down directions into single steps. For example, instead of "wash your face," start with "pick up washcloth" and take it one step at a time.
Caregiver is fatigued, not feeling well, and/or depressed and coming through in messages that are more stern or terse than meant. Person with the disease may be picking up on facial expression as well.
Assess for depressive symptoms in caregiver.
If depressed, possible interventions might include antidepressant, support groups, counseling and/ or additional respite care.
Assess amount and quality of sleep in the caregiver.
If sleep deprivation is unrelated to depression, consider sleep deprivation due to sleep disturbance in their loved one. Page 36
Assess physical status of caregiver.
Encourage self care. Assess for any barriers — financial, logistical or other that might limit access to self care.

Delirium

Indicators of possible delirium include: acute state of increased confusion, inattention, sudden increases in agitation, sudden emergence of psychosis, changes in sleep patterns, acute onset — hours to a couple of days and has fluctuating level of consciousness over the course of the day. Delirium is always caused by something physical and 25 percent can be fatal if underlying cause is not found. Delirium is considered a medical emergency.

Make sure the physician, physician's nurse and/or hospital personnel understand the person's baseline, timing of changes and all information that might be connected with the sudden change.

Recent hospitalization?

Discuss current presentation with physician.

Are there indications of dehydration? How often and how much water are they drinking?

In rare occasions, delirium can be provoked by water toxicity caused by drinking excessive amounts of water. Typically more of a risk for individuals who have had some historical mental health challenges.

Ensure adequate fluid intake. Offer with straw, encourage sips of water when walking by, incorporate sips of water throughout activities.

Contact physician.

Alcohol use? Are you sure?

Avoid any alcohol use. Non alcohol beverages can be served in wine glasses if part of long-term pattern.

Requires lab work to assess for possible Urinary Tract Infection. UTI's are common in people with Alzheimer's and related dementias. They often are reoccurring.

Contact physician immediately. Share your concerns and speculation of what it might be. An emergency room visit may be indicated.

New medications (either prescribed or over the counter) or recent increase in dosage or change in time existing medications are given?

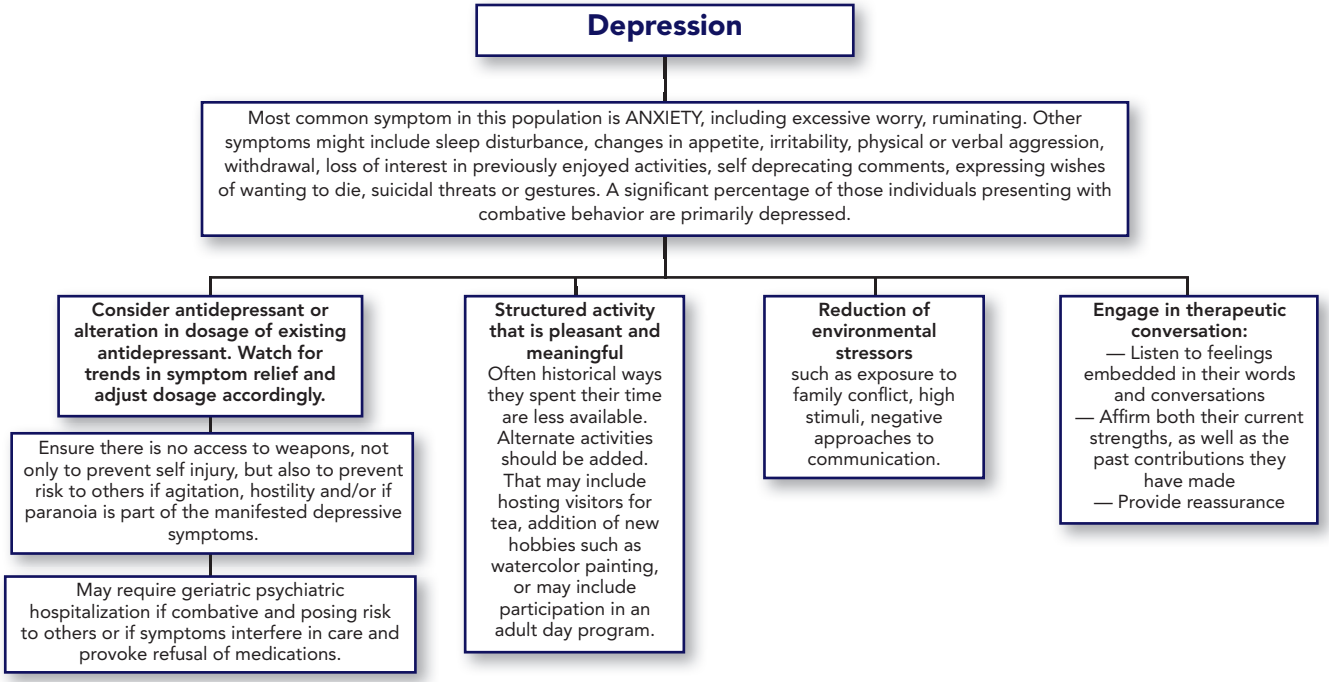
Contact physician immediately.

Is there a possibility the person could be accidentally taking medication incorrectly?

Contact physician immediately. Provide monitoring and supervision for medication.

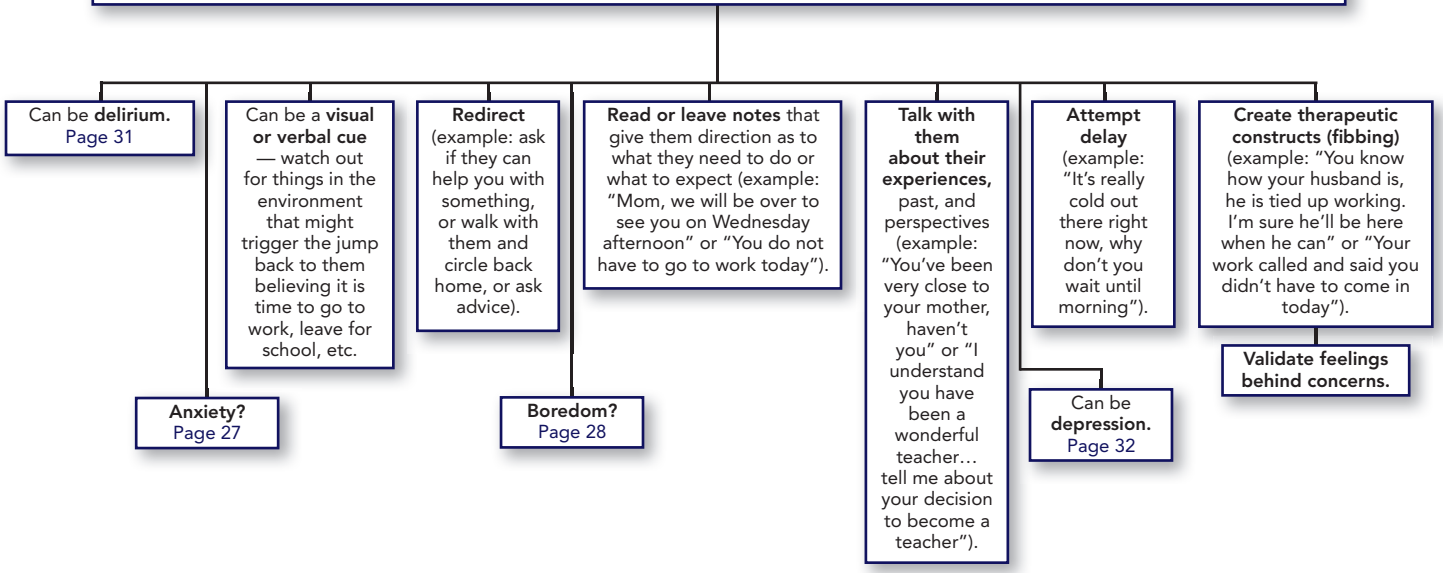
Are there indications of possible constipation/ impaction? (indicators can include: abdominal pain, loss of appetite, and even fecal incontinence as a result of pressure/ blockage).

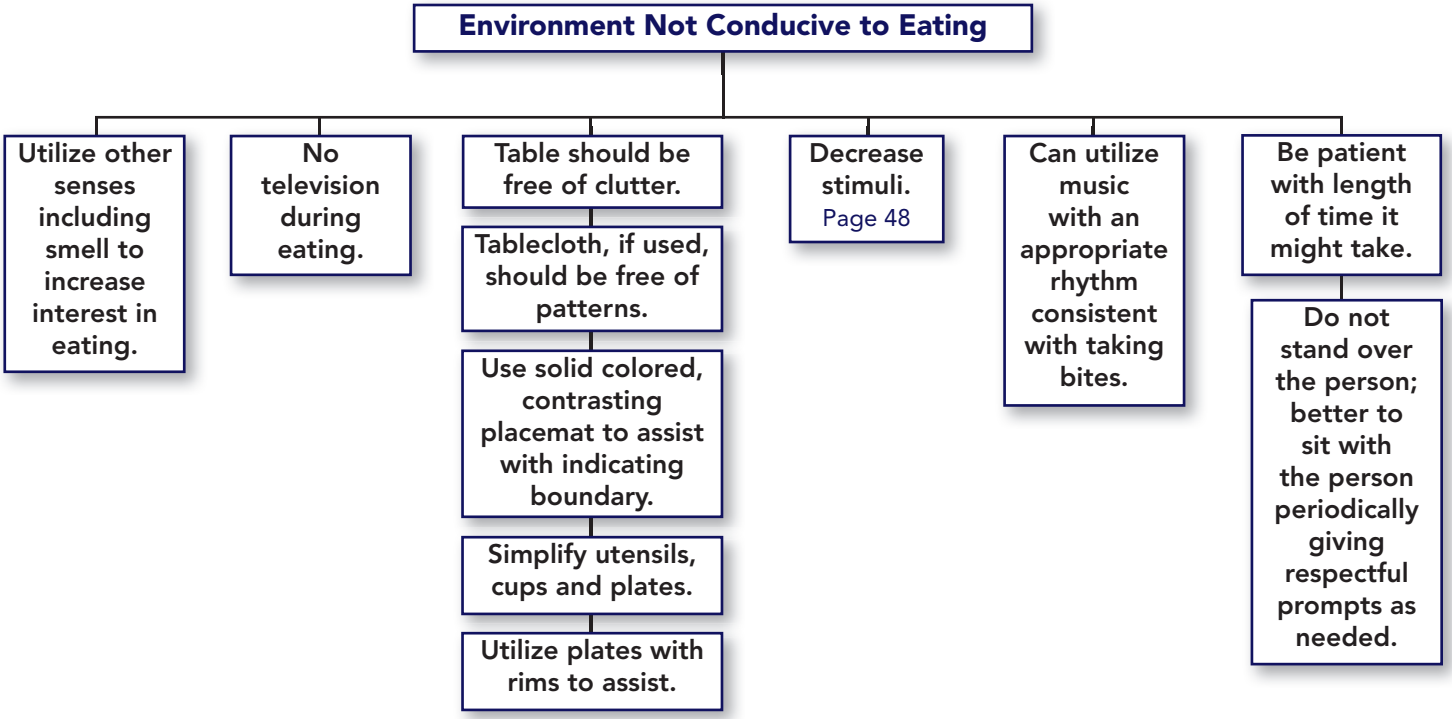
Contact physician immediately.

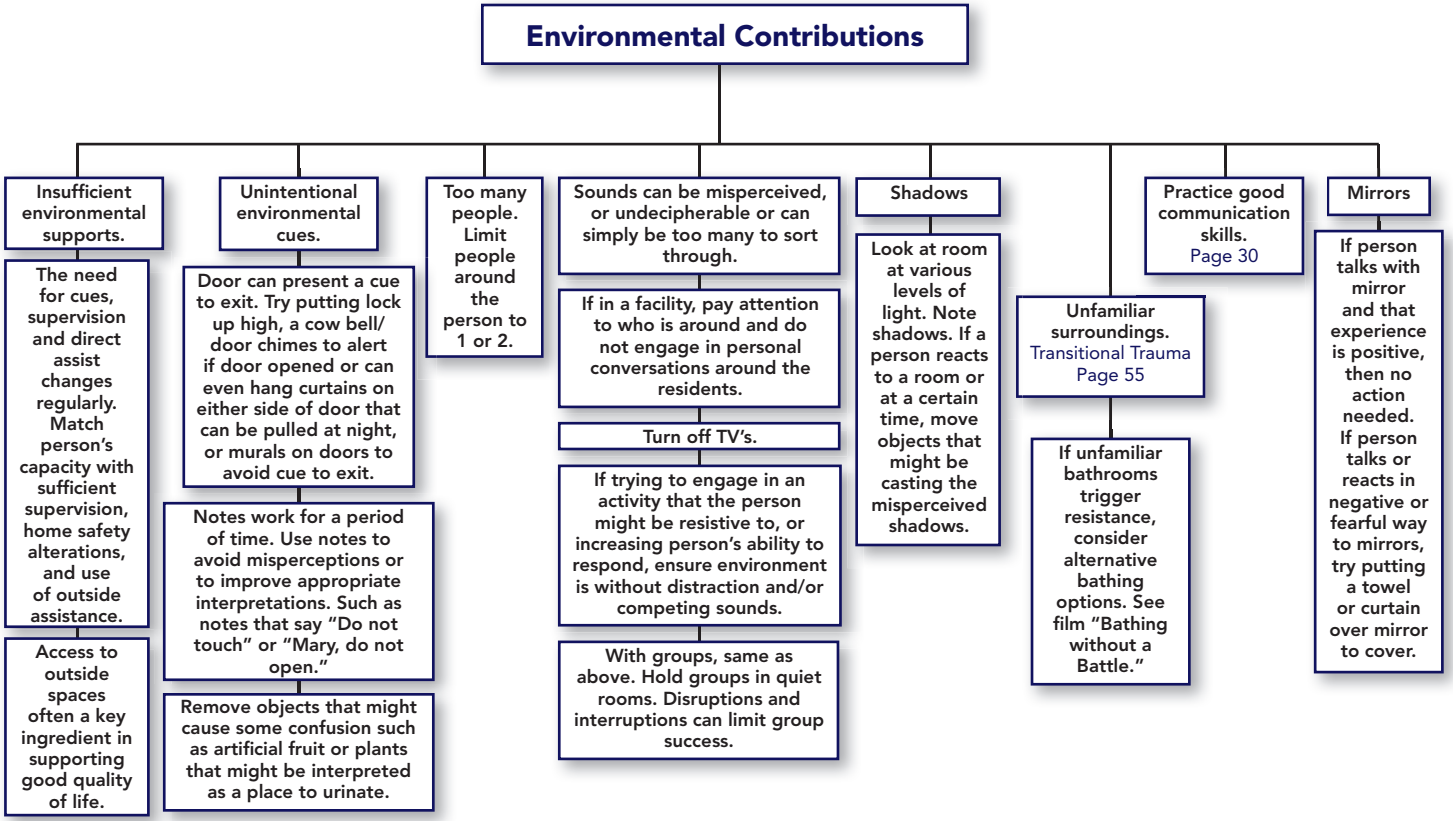

Depression
Most common symptom in this population is ANXIETY, including excessive worry, ruminating. Other symptoms might include sleep disturbance, changes in appetite, irritability, physical or verbal aggression, withdrawal, loss of interest in previously enjoyed activities, self deprecating comments, expressing wishes of wanting to die, suicidal threats or gestures. A significant percentage of those individuals presenting with combative behavior are primarily depressed.
Consider antidepressant or alteration in dosage of existing antidepressant. Watch for trends in symptom relief and adjust dosage accordingly.
Ensure there is no access to weapons, not only to prevent self injury, but also to prevent risk to others if agitation, hostility and/or if paranoia is part of the manifested depressive symptoms.
May require geriatric psychiatric hospitalization if combative and posing risk to others or if symptoms interfere in care and provoke refusal of medications.
Structured activity that is pleasant and meaningful
Often historical ways they spent their time are less available. Alternate activities should be added. That may include hosting visitors for tea, addition of new hobbies such as watercolor painting, or may include participation in an adult day program.
Reduction of environmental stressors
such as exposure to family conflict, high stimuli, negative approaches to communication.
Engage in therapeutic conversation:
— Listen to feelings embedded in their words and conversations
— Affirm both their current strengths, as well as the past contributions they have made
— Provide reassurance

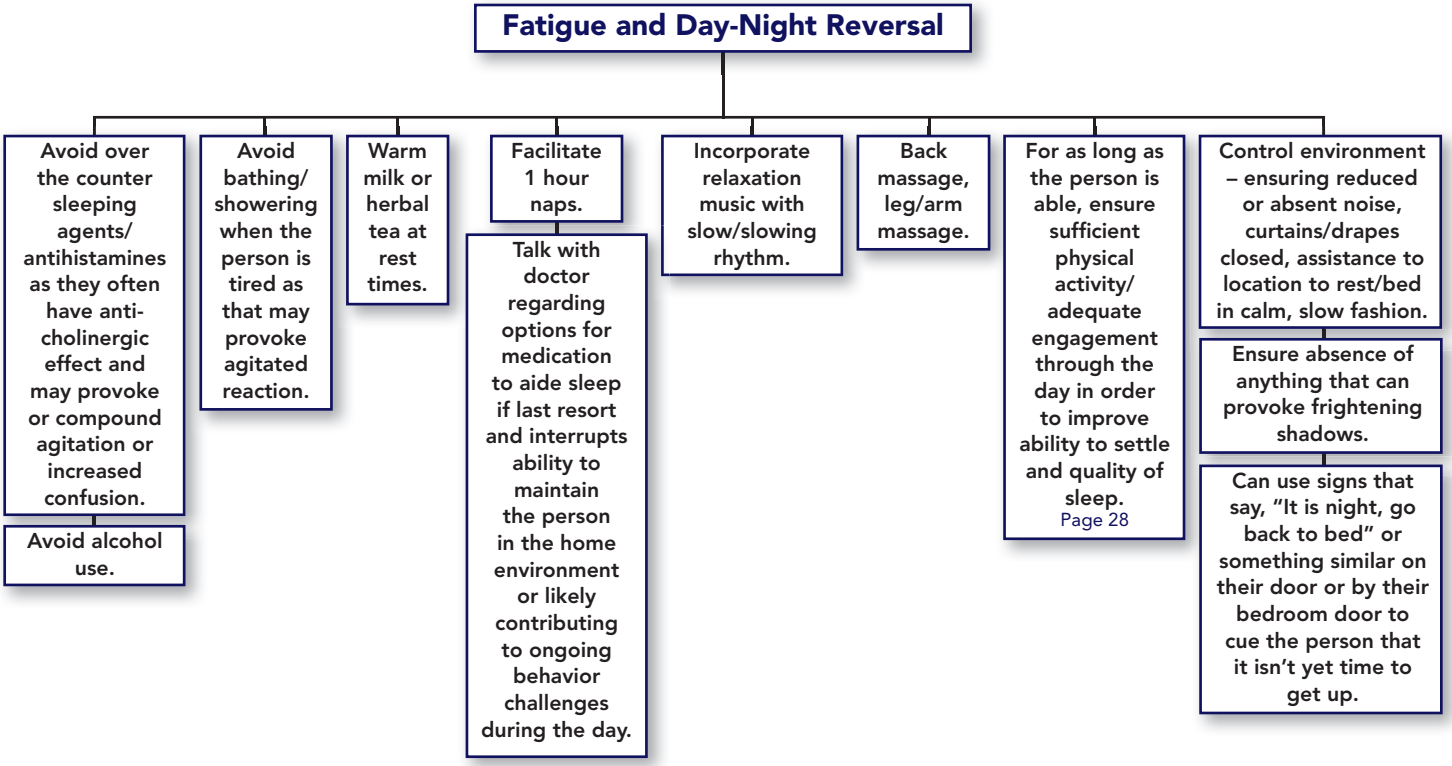
Desire to Fulfill Former Obligations

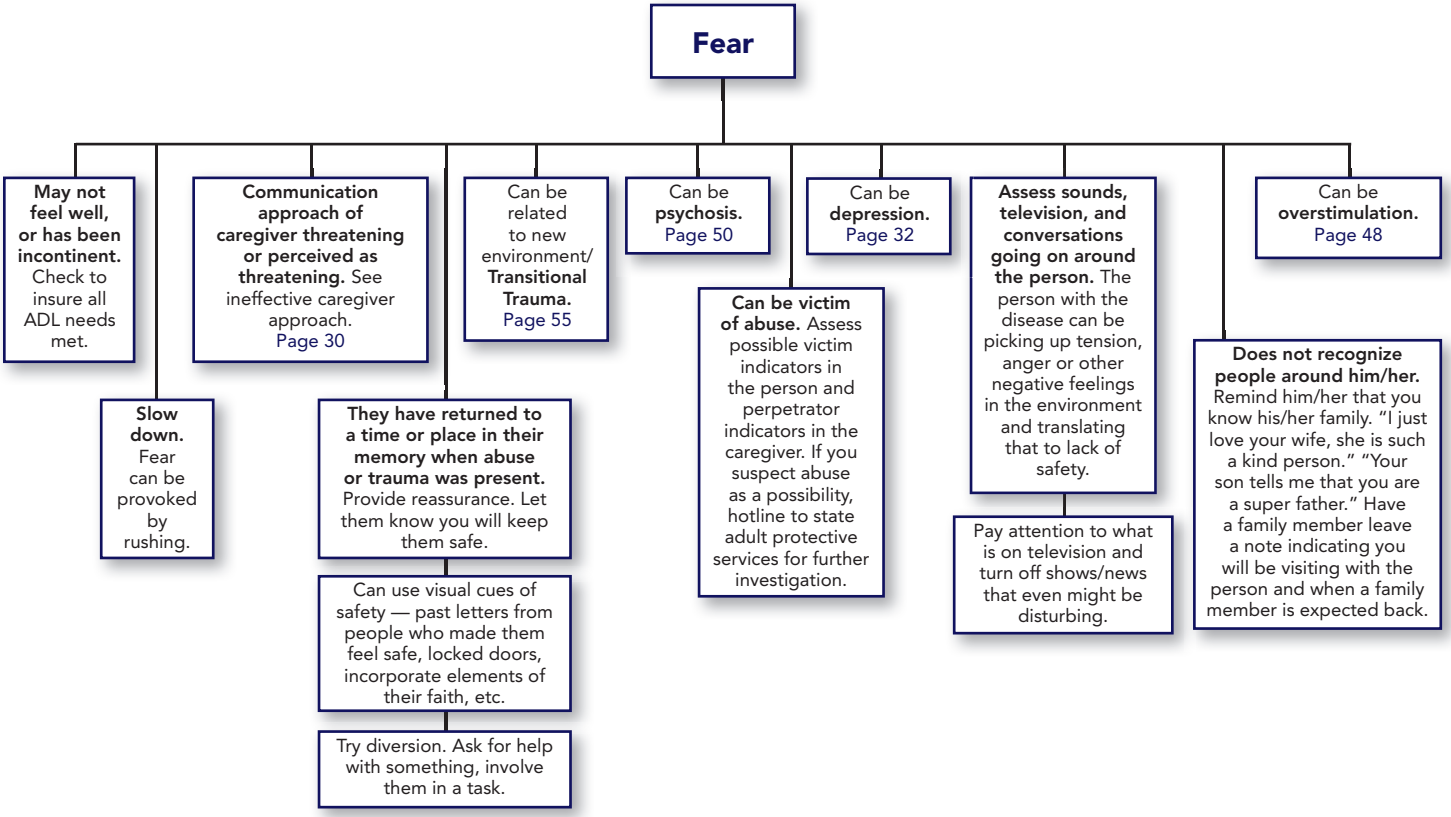
(Wanting to go home or to work or to pick up kids or other demands that reflect back to an earlier time in their lives)




Environment Not Conducive to Eating
Utilize other senses including smell to increase interest in eating.
No television during eating.
Table should be free of clutter.
Tablecloth, if used, should be free of patterns.
Use solid colored, contrasting placemat to assist with indicating boundary.
Simplify utensils, cups and plates.
Utilize plates with rims to assist.
Decrease stimuli.
Page 48
Can utilize music with an appropriate rhythm consistent with taking bites.
Be patient with length of time it might take.
Do not stand over the person; better to sit with the person periodically giving respectful prompts as needed.


Environmental Contributions
Insufficient environmental supports.
The need for cues, supervision and direct assist changes regularly. Match person's capacity with sufficient supervision, home safety alterations, and use of outside assistance.
Access to outside spaces often a key ingredient in supporting good quality of life.
Unintentional environmental cues.
Door can present a cue to exit. Try putting lock up high, a cow bell/ door chimes to alert if door opened or can even hang curtains on either side of door that can be pulled at night, or murals on doors to avoid cue to exit.
Notes work for a period of time. Use notes to avoid misperceptions or to improve appropriate interpretations. Such as notes that say "Do not touch" or "Mary, do not open."
Remove objects that might cause some confusion such as artificial fruit or plants that might be interpreted as a place to urinate.
Too many people. Limit people around the person to 1 or 2.
Sounds can be misperceived, or undecipherable or can simply be too many to sort through.
If in a facility, pay attention to who is around and do not engage in personal conversations around the residents.
Turn off TV's.
If trying to engage in an activity that the person might be resistive to, or increasing person's ability to respond, ensure environment is without distraction and/or competing sounds.
With groups, same as above. Hold groups in quiet rooms. Disruptions and interruptions can limit group success.
Shadows
Look at room at various levels of light. Note shadows. If a person reacts to a room or at a certain time, move objects that might be casting the misperceived shadows.
Unfamiliar surroundings.
Transitional Trauma
Page 55
If unfamiliar bathrooms trigger resistance, consider alternative bathing options. See film "Bathing without a Battle."
Practice good communication skills.
Page 30
Mirrors
If person talks with mirror and that experience is positive, then no action needed. If person talks or reacts in negative or fearful way to mirrors, try putting a towel or curtain over mirror to cover.

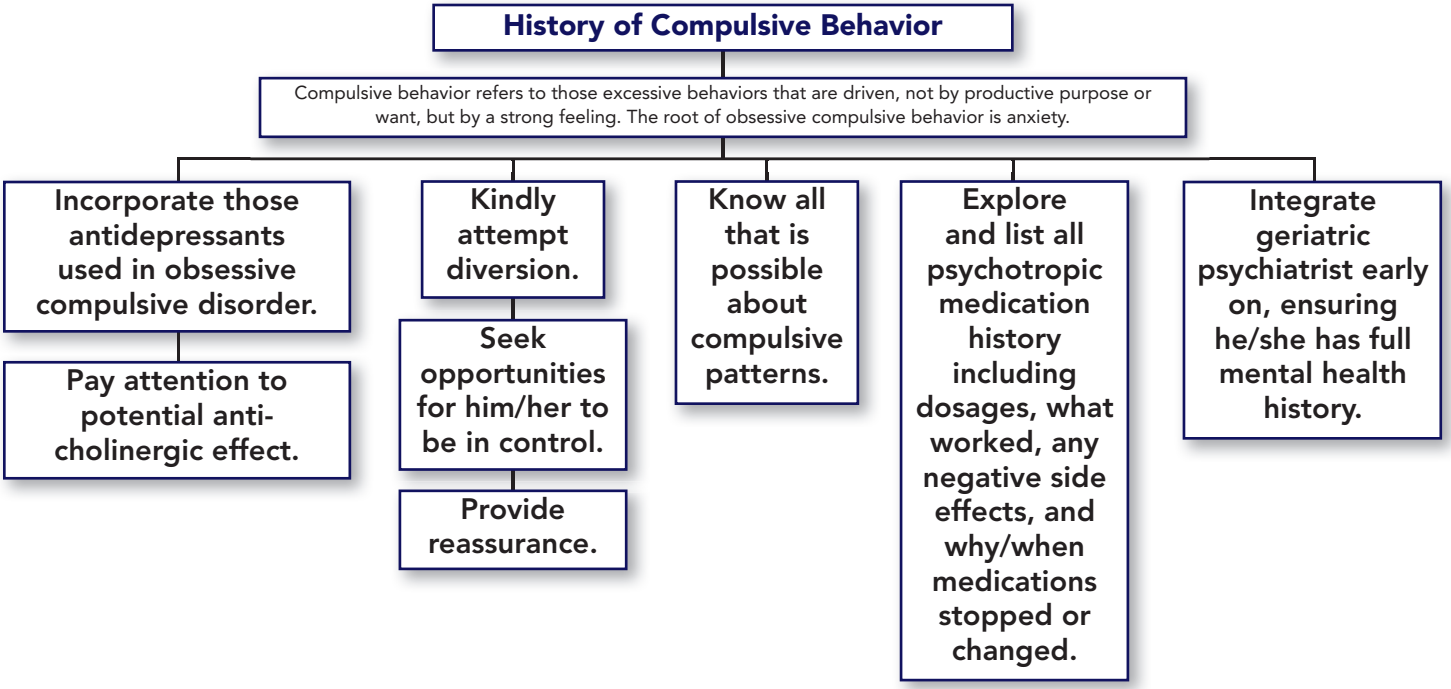

Fatigue and Day-Night Reversal
Avoid over the counter sleeping agents/ antihistamines as they often have anti-cholinergic effect and may provoke or compound agitation or increased confusion.
Avoid alcohol use.
Avoid bathing/ showering when the person is tired as that may provoke agitated reaction.
Warm milk or herbal tea at rest times.
Facilitate 1 hour naps.
Talk with doctor regarding options for medication to aide sleep if last resort and interrupts ability to maintain the person in the home environment or likely contributing to ongoing behavior challenges during the day.
Incorporate relaxation music with slow/slowing rhythm.
Back massage, leg/arm massage.
For as long as the person is able, ensure sufficient physical activity/ adequate engagement through the day in order to improve ability to settle and quality of sleep.
Page 28
Control environment – ensuring reduced or absent noise, curtains/drapes closed, assistance to location to rest/bed in calm, slow fashion.
Ensure absence of anything that can provoke frightening shadows.
Can use signs that say, "It is night, go back to bed" or something similar on their door or by their bedroom door to cue the person that it isn't yet time to get up.

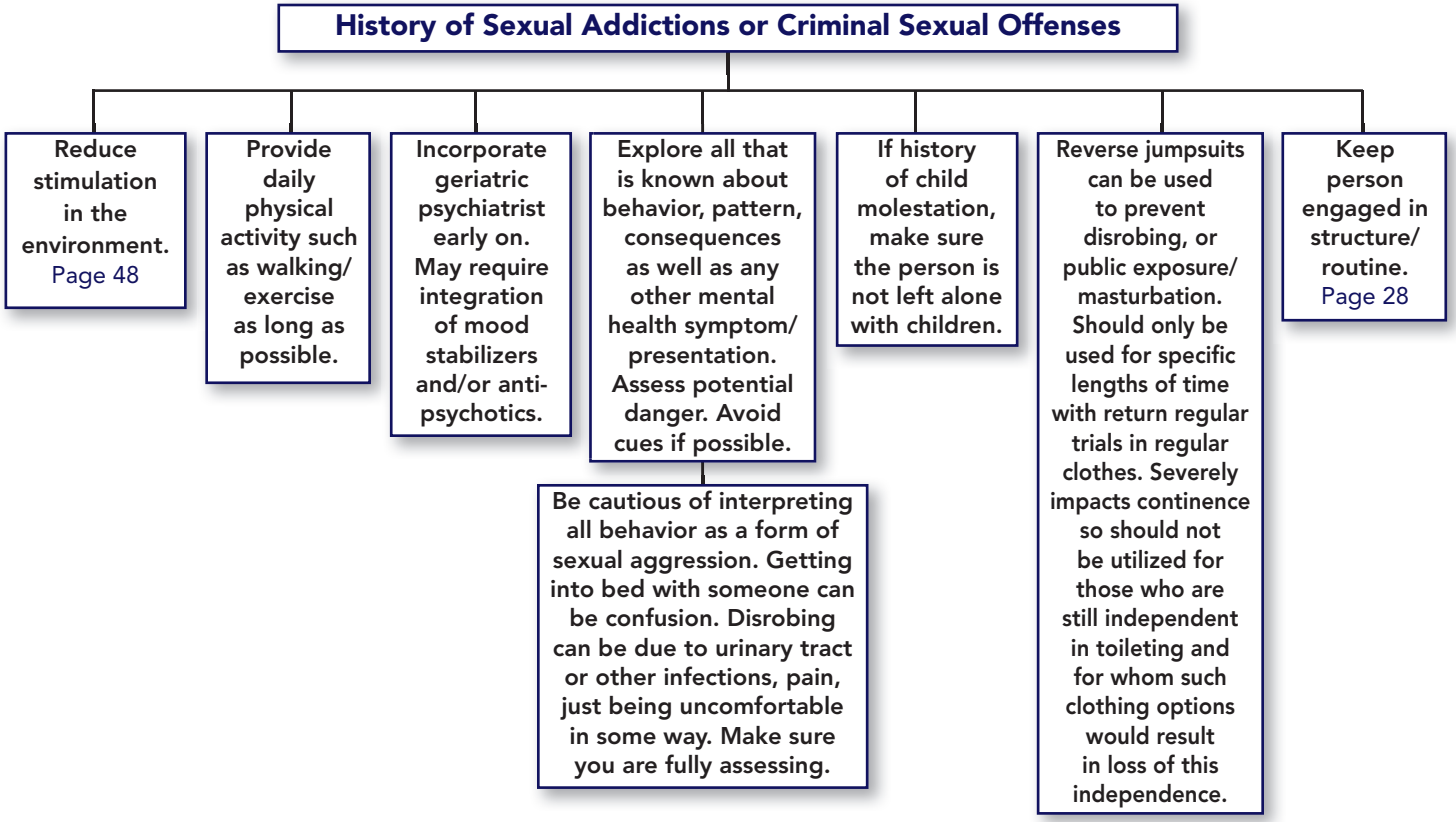

Fear
May not feel well, or has been incontinent. Check to insure all ADL needs met.
Slow down. Fear can be provoked by rushing.
Communication approach of caregiver threatening or perceived as threatening. See ineffective caregiver approach. Page 30
They have returned to a time or place in their memory when abuse or trauma was present. Provide reassurance. Let them know you will keep them safe.
Can use visual cues of safety — past letters from people who made them feel safe, locked doors, incorporate elements of their faith, etc.
Try diversion. Ask for help with something, involve them in a task.
Can be related to new environment/ Transitional Trauma. Page 55
Can be psychosis. Page 50
Can be victim of abuse. Assess possible victim indicators in the person and perpetrator indicators in the caregiver. If you suspect abuse as a possibility, hotline to state adult protective services for further investigation.
Can be depression. Page 32
Assess sounds, television, and conversations going on around the person. The person with the disease can be picking up tension, anger or other negative feelings in the environment and translating that to lack of safety.
Pay attention to what is on television and turn off shows/news that even might be disturbing.
Can be overstimulation. Page 48
Does not recognize people around him/her. Remind him/her that you know his/her family. "I just love your wife, she is such a kind person." "Your son tells me that you are a super father." Have a family member leave a note indicating you will be visiting with the person and when a family member is expected back.

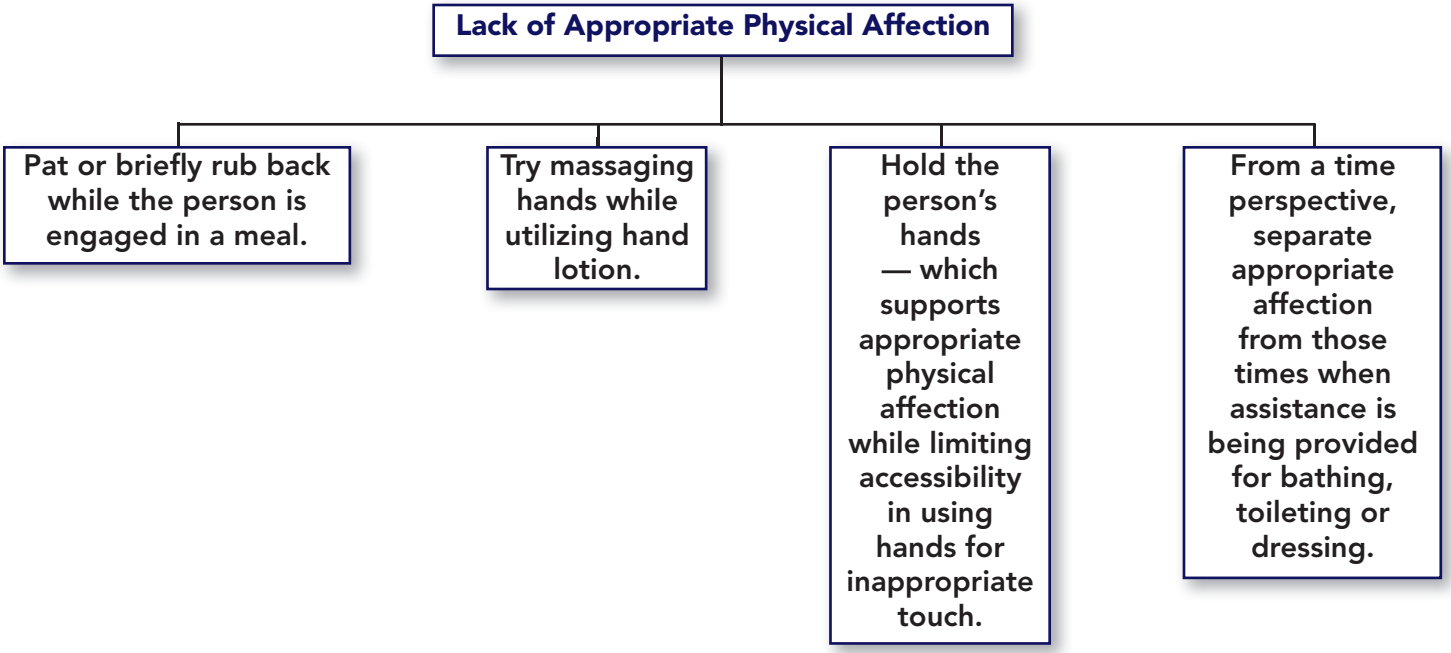
Grief

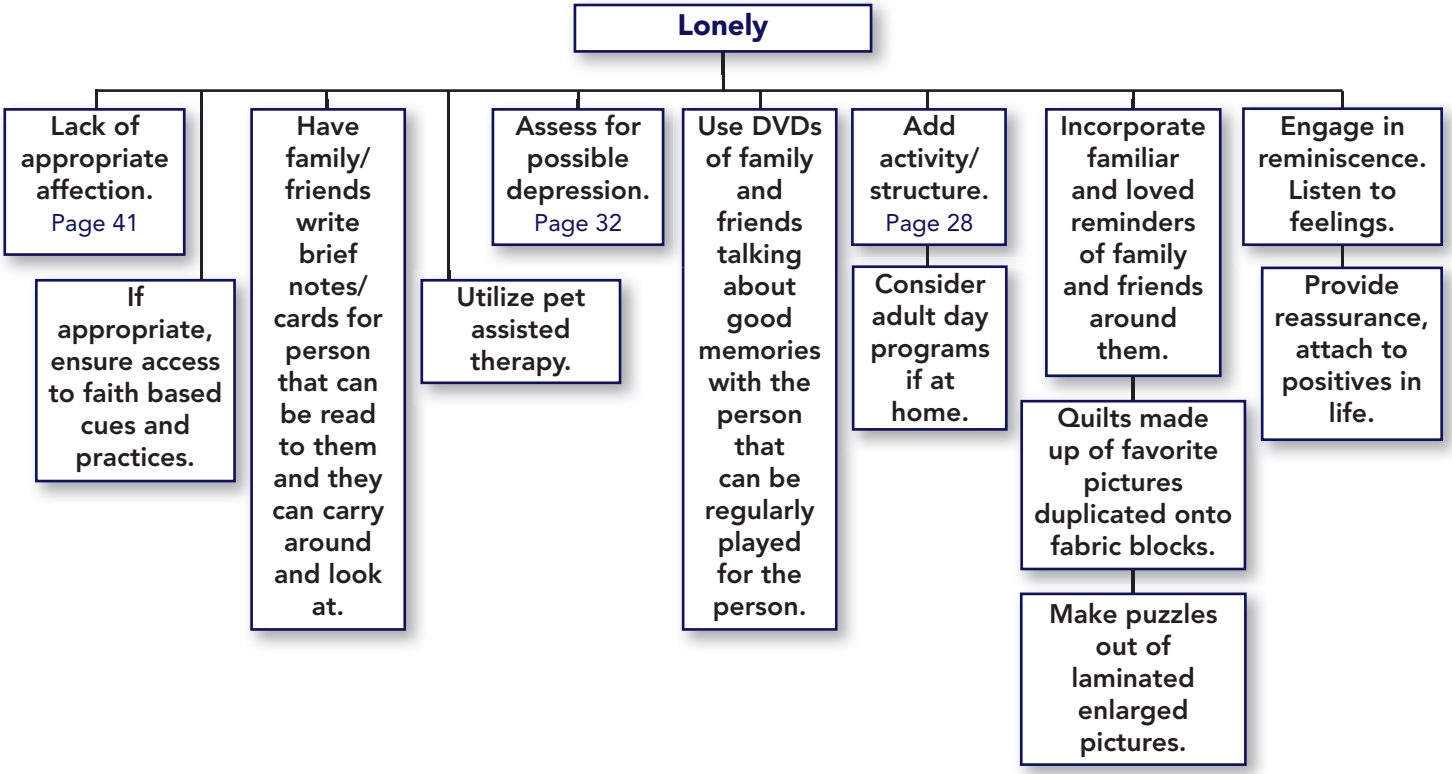
- Offer avenues of projection — activities/conversations that allow a person to share feelings without claiming it as their own.
  - Time Slips. www.timeslips.org
  - Memories in the Making© or other art related projects. Contact the Alzheimer's Association for more information
  - Reading poetry or stories with the person and discussing feelings.
  - Use of music — listening, singing, discussing place in history.
- Assess historical coping strategies. How did they react to difficult situations in the past? Did they reach out to others, work outside, through their faith, get busy in other things, work, try to fix? Understanding those coping strategies is just as valuable, and sometimes more so, than knowing any other piece of their social history.
  - Explore avenues of replication. For example, if they coped by calling family, play taped or videotaped messages from families sharing ways the person has contributed to life, assist the person with calling friends and/or family, keep person connected to others, assist with writing letters to friends and family.
  - Other example might include if a person coped with challenges by using nature/gardening/walking, then include walking prior to higher risk times or activities. Or support them in sitting outside on a glider when movement can occur, or work with them on weeding or planting.
- Hear the sadness related to losses, not what you assume they might be sad about, but what you hear and see in the person.
  - LISTEN to the feelings in their messages even if language difficulties.
  - Acknowledge presence of feelings ("It has to be very hard for you.")
  - Acknowledge strength in the person, including the positive ways they dealt with past losses. ("You've always been such a rock to your family".)
  - Incorporate quiet spaces. Sometimes just sitting and holding someone's hand and being with them is the primary needed intervention.
  - Engage in reminiscence — asking questions about feelings and acknowledging strengths seen.
- Add structure/routine. Page 28

Consider use of antidepressant if sadness consistent over period of time and unremitted by non-pharmacological interventions.


History of Compulsive Behavior
Compulsive behavior refers to those excessive behaviors that are driven, not by productive purpose or want, but by a strong feeling. The root of obsessive compulsive behavior is anxiety.
Incorporate those antidepressants used in obsessive compulsive disorder.
Pay attention to potential anti-cholinergic effect.
Kindly attempt diversion.
Seek opportunities for him/her to be in control.
Provide reassurance.
Know all that is possible about compulsive patterns.
Explore and list all psychotropic medication history including dosages, what worked, any negative side effects, and why/when medications stopped or changed.
Integrate geriatric psychiatrist early on, ensuring he/she has full mental health history.


History of Sexual Addictions or Criminal Sexual Offenses
Reduce stimulation in the environment. Page 48
Provide daily physical activity such as walking/ exercise as long as possible.
Incorporate geriatric psychiatrist early on. May require integration of mood stabilizers and/or anti-psychotics.
Explore all that is known about behavior, pattern, consequences as well as any other mental health symptom/ presentation. Assess potential danger. Avoid cues if possible.
Be cautious of interpreting all behavior as a form of sexual aggression. Getting into bed with someone can be confusion. Disrobing can be due to urinary tract or other infections, pain, just being uncomfortable in some way. Make sure you are fully assessing.
If history of child molestation, make sure the person is not left alone with children.
Reverse jumpsuits can be used to prevent disrobing, or public exposure/ masturbation. Should only be used for specific lengths of time with return regular trials in regular clothes. Severely impacts continence so should not be utilized for those who are still independent in toileting and for whom such clothing options would result in loss of this independence.
Keep person engaged in structure/ routine. Page 28

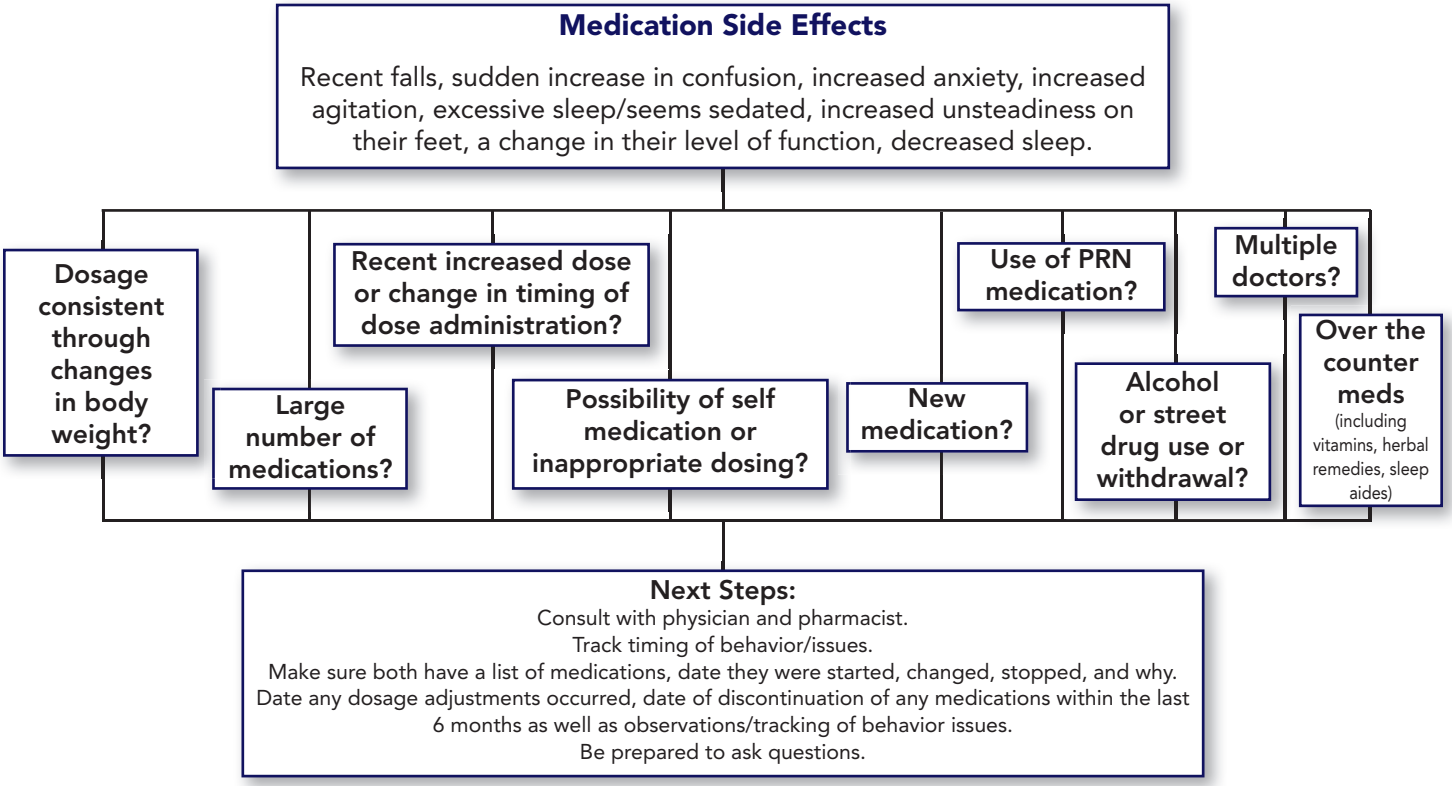

Lack of Appropriate Physical Affection
Pat or briefly rub back while the person is engaged in a meal.
Try massaging hands while utilizing hand lotion.
Hold the person's hands — which supports appropriate physical affection while limiting accessibility in using hands for inappropriate touch.
From a time perspective, separate appropriate affection from those times when assistance is being provided for bathing, toileting or dressing.
If inappropriate touching or consistent inappropriate sexually oriented conversation continues over the course of time and unaltered by non pharmacological efforts, consider geriatric psychiatric consult.

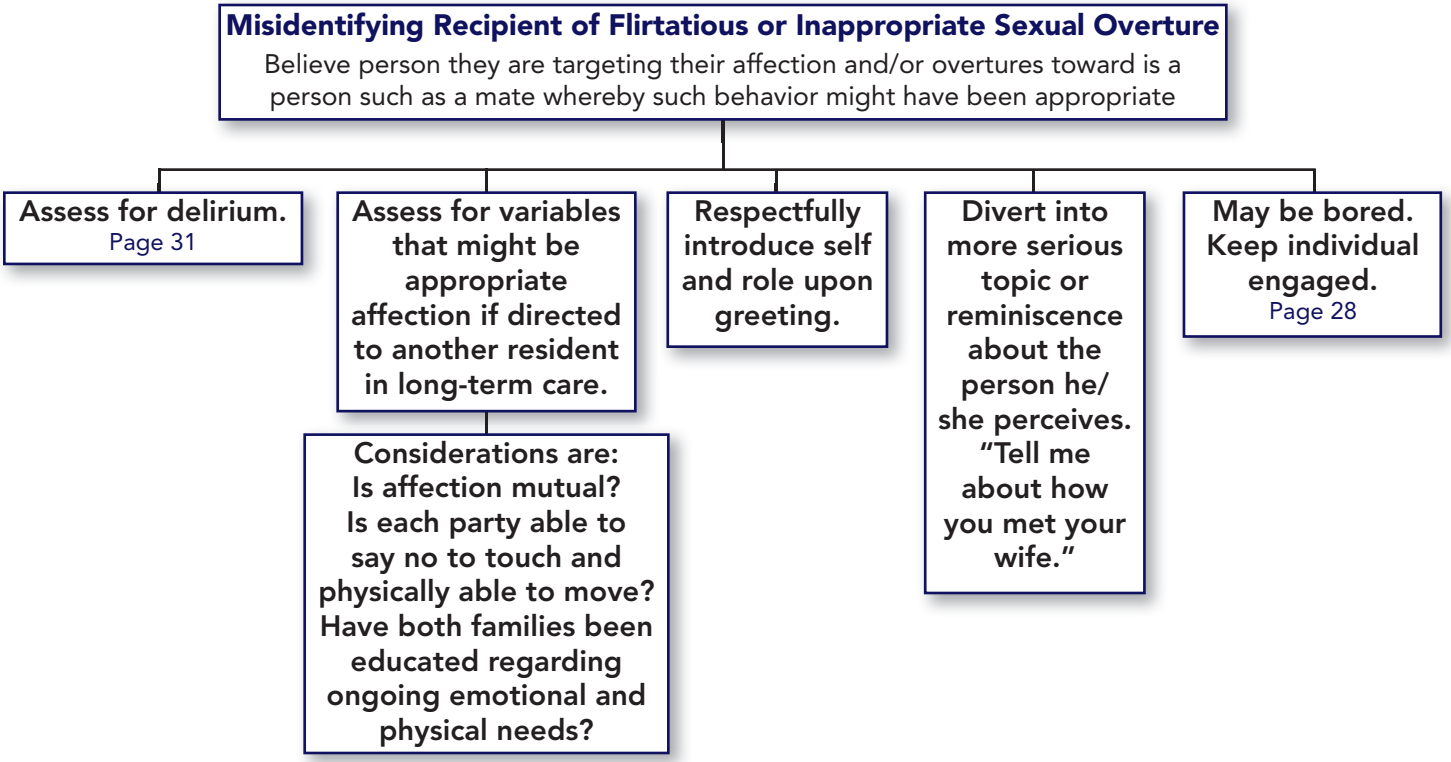

Lonely
Lack of appropriate affection.
Page 41
If appropriate, ensure access to faith based cues and practices.
Have family/ friends write brief notes/ cards for person that can be read to them and they can carry around and look at.
Assess for possible depression.
Page 32
Utilize pet assisted therapy.
Use DVDs of family and friends talking about good memories with the person that can be regularly played for the person.
Add activity/ structure.
Page 28
Consider adult day programs if at home.
Incorporate familiar and loved reminders of family and friends around them.
Quilts made up of favorite pictures duplicated onto fabric blocks.
Make puzzles out of laminated enlarged pictures.
Engage in reminiscence. Listen to feelings.
Provide reassurance, attach to positives in life.

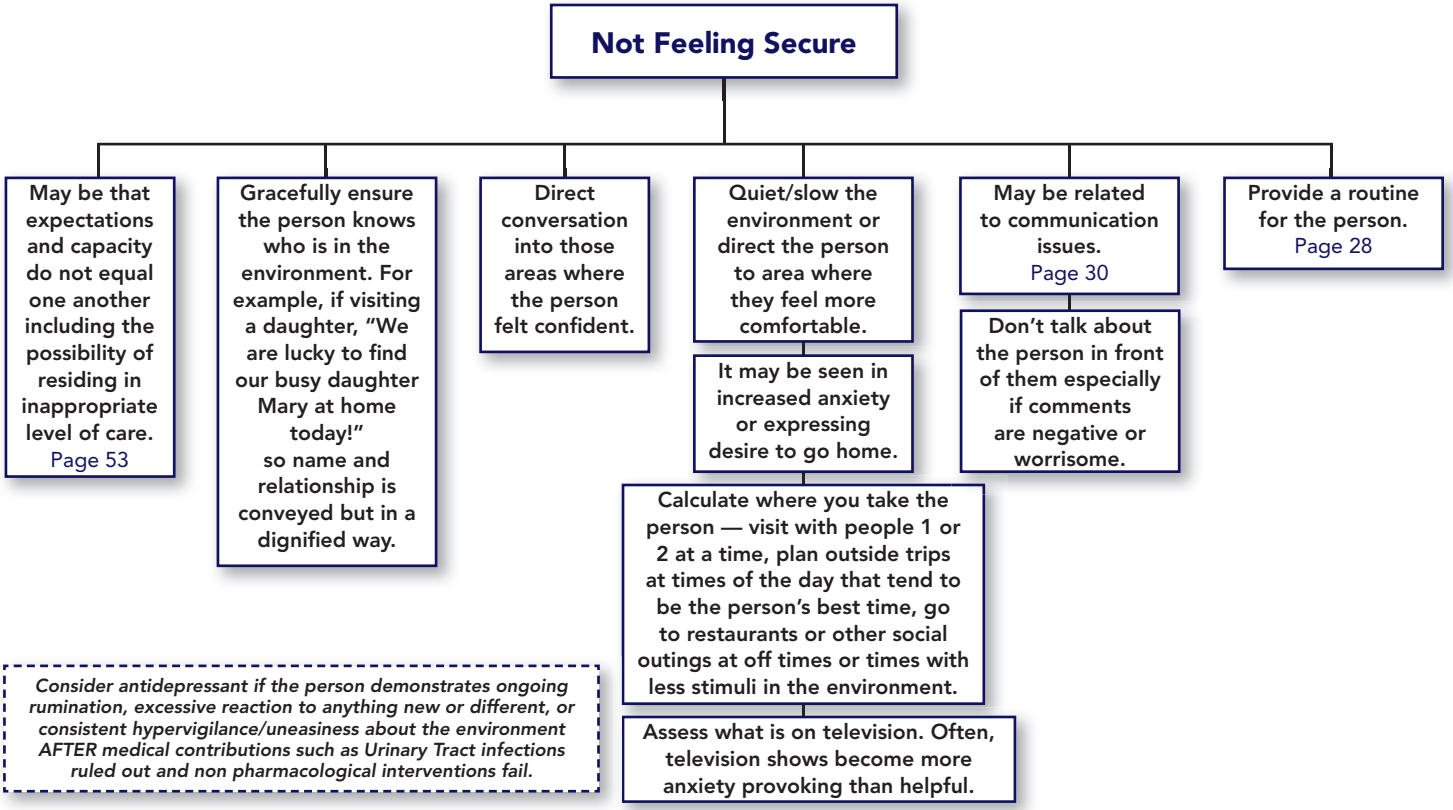
Loss of Ability to Control Impulses

The frontal lobes of the brain are significantly impacted in Alzheimer's disease as well as other dementias. The frontal lobes serve as our filter between thought and action. When this part of the brain is damaged, then reactions to thoughts as well as environmental cues and frustrations can be immediate.

- **Use business cards that say, "My companion has Alzheimer's disease, please be patient" and subtly extend to waiters and others who may or may not understand inappropriate comments or actions.**
- **Do not scold or attempt to utilize behavior modification techniques.**
- **Practice good communication skills.** Page 30
- **Pay attention to possible depressive symptoms.** Page 32
- **Reduce environmental stimuli.** Page 48
- **Monitor environmental cues.** Page 56
- **Maintain balance between expectation and capacity.** Page 53
- **Do not persist in conversations that seem to go in a circle. The person with the disease likely will not be able to be convinced. If caregiver stays in circular dialogue, chances are high for agitation.**
- **Maintain routine/ structure.** Page 28


Medication Side Effects
Recent falls, sudden increase in confusion, increased anxiety, increased agitation, excessive sleep/seems sedated, increased unsteadiness on their feet, a change in their level of function, decreased sleep.
Dosage consistent through changes in body weight?
Large number of medications?
Recent increased dose or change in timing of dose administration?
Possibility of self medication or inappropriate dosing?
New medication?
Use of PRN medication?
Alcohol or street drug use or withdrawal?
Multiple doctors?
Over the counter meds (including vitamins, herbal remedies, sleep aides)
Next Steps:
Consult with physician and pharmacist.
Track timing of behavior/issues.
Make sure both have a list of medications, date they were started, changed, stopped, and why.
Date any dosage adjustments occurred, date of discontinuation of any medications within the last 6 months as well as observations/tracking of behavior issues.
Be prepared to ask questions.


Misidentifying Recipient of Flirtatious or Inappropriate Sexual Overture
Believe person they are targeting their affection and/or overtures toward is a person such as a mate whereby such behavior might have been appropriate
Assess for delirium.
Page 31
Assess for variables that might be appropriate affection if directed to another resident in long-term care.
Considerations are:
Is affection mutual?
Is each party able to say no to touch and physically able to move?
Have both families been educated regarding ongoing emotional and physical needs?
Respectfully introduce self and role upon greeting.
Divert into more serious topic or reminiscence about the person he/she perceives. "Tell me about how you met your wife."
May be bored. Keep individual engaged.
Page 28


Not Feeling Secure
May be that expectations and capacity do not equal one another including the possibility of residing in inappropriate level of care.
Page 53
Gracefully ensure the person knows who is in the environment. For example, if visiting a daughter, "We are lucky to find our busy daughter Mary at home today!" so name and relationship is conveyed but in a dignified way.
Direct conversation into those areas where the person felt confident.
Quiet/slow the environment or direct the person to area where they feel more comfortable.
It may be seen in increased anxiety or expressing desire to go home.
Calculate where you take the person — visit with people 1 or 2 at a time, plan outside trips at times of the day that tend to be the person's best time, go to restaurants or other social outings at off times or times with less stimuli in the environment.
Assess what is on television. Often, television shows become more anxiety provoking than helpful.
May be related to communication issues.
Page 30
Don't talk about the person in front of them especially if comments are negative or worrisome.
Provide a routine for the person.
Page 28
Consider antidepressant if the person demonstrates ongoing rumination, excessive reaction to anything new or different, or consistent hypervigilance/uneasiness about the environment AFTER medical contributions such as Urinary Tract infections ruled out and non pharmacological interventions fail.

Overwhelmed by Choices

Overwhelmed by clothing/dressing choices.

- Give two choices, with dignified cues for one, if the person struggles with the choice. "Do you want to wear the red shirt or the blue shirt? I have always thought you look so pretty in the blue shirt."
- Lay out the person's clothes in the order they will put them on.
- Hand things to the person one at a time.
- Simplify closet.
- If the person picks the same thing all the time, have duplicates of these favorite pieces.
- Allow sufficient time.
- Break down tasks.

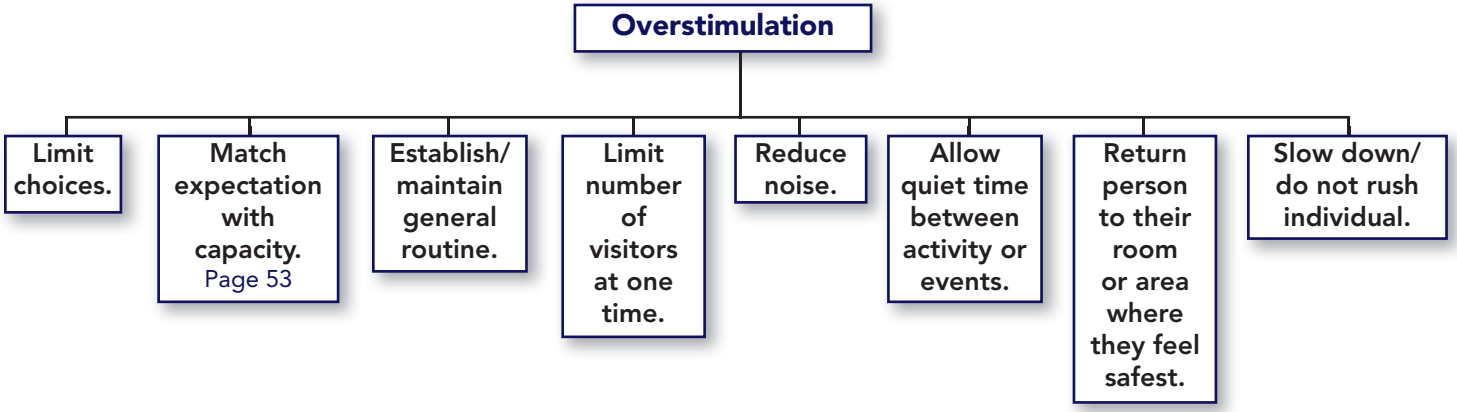
Page 30

Overwhelmed/reacting to too many pills.

- Talk with doctor about which medication is essential.
- Talk with pharmacist re: taste of medication/ which ones can be safely crushed in food such as mint ice cream (which can cover taste of medication) or apple sauce.
- Talk with doctor re: spreading timing of medications through the day to avoid too many pills given at the same time.
- Divert into enjoyable conversations as you give the medication.

Overwhelmed by food choices.

- When in a restaurant, supply clues that the person can utilize, such as, "I'm wondering if you are going to have your favorite pork chop" or "Let me see if I can guess what you are going to have — the pork chop, am I right?"
- For some people, as disease progresses, food choices should be given one item at a time.
- Provide one utensil, such as a fork, and make sure all food served can be eaten with that one utensil to avoid confusion about changing utensils.
- If tablecloths are used, make sure they are absent of pattern and have contrast to plate/food.
- Eat with the person to extend visual cue.
- Try putting your hand on theirs just to get them started.


Overstimulation
Limit choices.
Match expectation with capacity.
Page 53
Establish/ maintain general routine.
Limit number of visitors at one time.
Reduce noise.
Allow quiet time between activity or events.
Return person to their room or area where they feel safest.
Slow down/ do not rush individual.

Pain

Intermittent
(migraines, other headaches, virus, GI reflux, etc.

Possible additional indicators:
Abrupt worsening of behavior, rapid pulse, refusal of fluids and food, increased irritability or increased drowsiness, grimacing, moaning or shouting which is new, sudden onset of falls, edema of any part of the body, increased pacing, change in sleep pattern, tearfulness, withdrawal from others, changes in mood, changes in level of arousal, psychomotor agitation.

Next steps:
Consult physician, sharing indicators and discussing possible pain medication. A person with progressed memory loss will be a poor reporter and may not be able to acknowledge discomfort or request a PRN. Provide comfort measures such as warm bath, repositioning, cushions, quiet environment. Be familiar with potential side effects of medication and monitor person. Monitor effect of medication and adjust as necessary per physician order.

Dental
(cavities, infections, sores, etc.)

Possible additional indicators:
Dentures not fitting properly, eating less, refusal to brush teeth, history of dental problems or history of poor oral care, escalation of behaviors with oral care, ongoing dry mouth (often side effect of a number of common medications), excessive drooling, white or discolored spots on gums or tongue.

Next steps:
Contact dentist. Ensure dentures fit. Brush dentures after meals and remove and soak nightly. Keep close eye on teeth, gums and tongue, and be aware of changes such as coloration or lesions. Ask dentist about alternative devices and oral products to ensure good oral care and reduce risk, including prescription strength fluoride toothpaste. Give the person water after bites, minimize "cheeking" of food. Label dentures.

Acute
(Angina, TIA, compression fractures, urinary tract infections, bowel impactions, etc.)

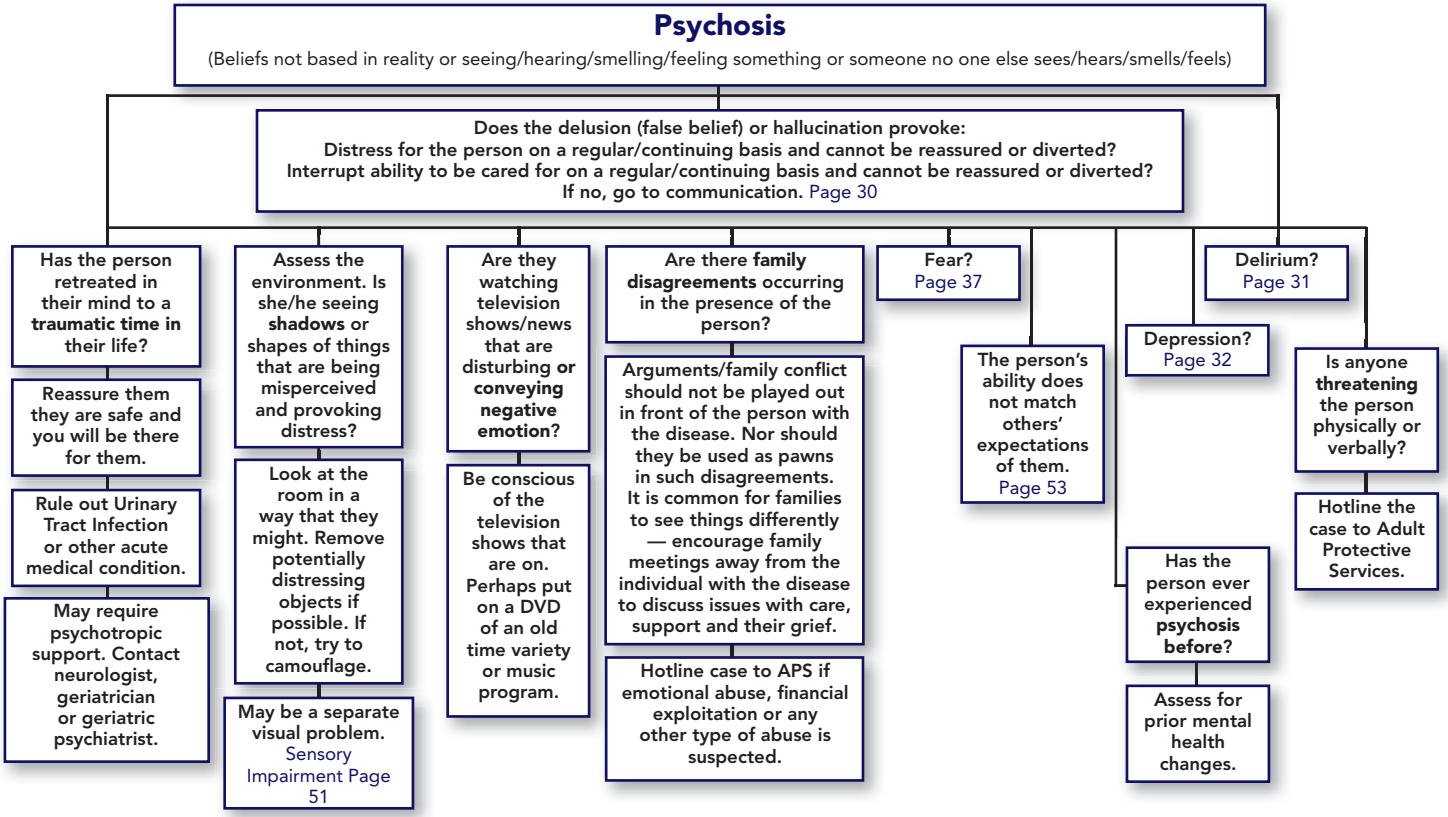
Possible additional indicators:
Abrupt worsening of behavior, rapid pulse, refusal of fluids and food, increased irritability or increased drowsiness, grimacing, moaning or shouting which is new, sudden onset of falls, edema of any part of the body, increased pacing, change in sleep pattern, fever, tearfulness, withdrawal from others, changes in mood, changes in level of arousal, psychomotor agitation, difficulty breathing, sudden weakness either generally or on one side, sudden changes in language – either speaking or understanding, period of time irresponsive, diarrhea/runny stool, sensitivity to touch in specific areas, odor in urine, dark urine, pain/hesitancy to urinate.

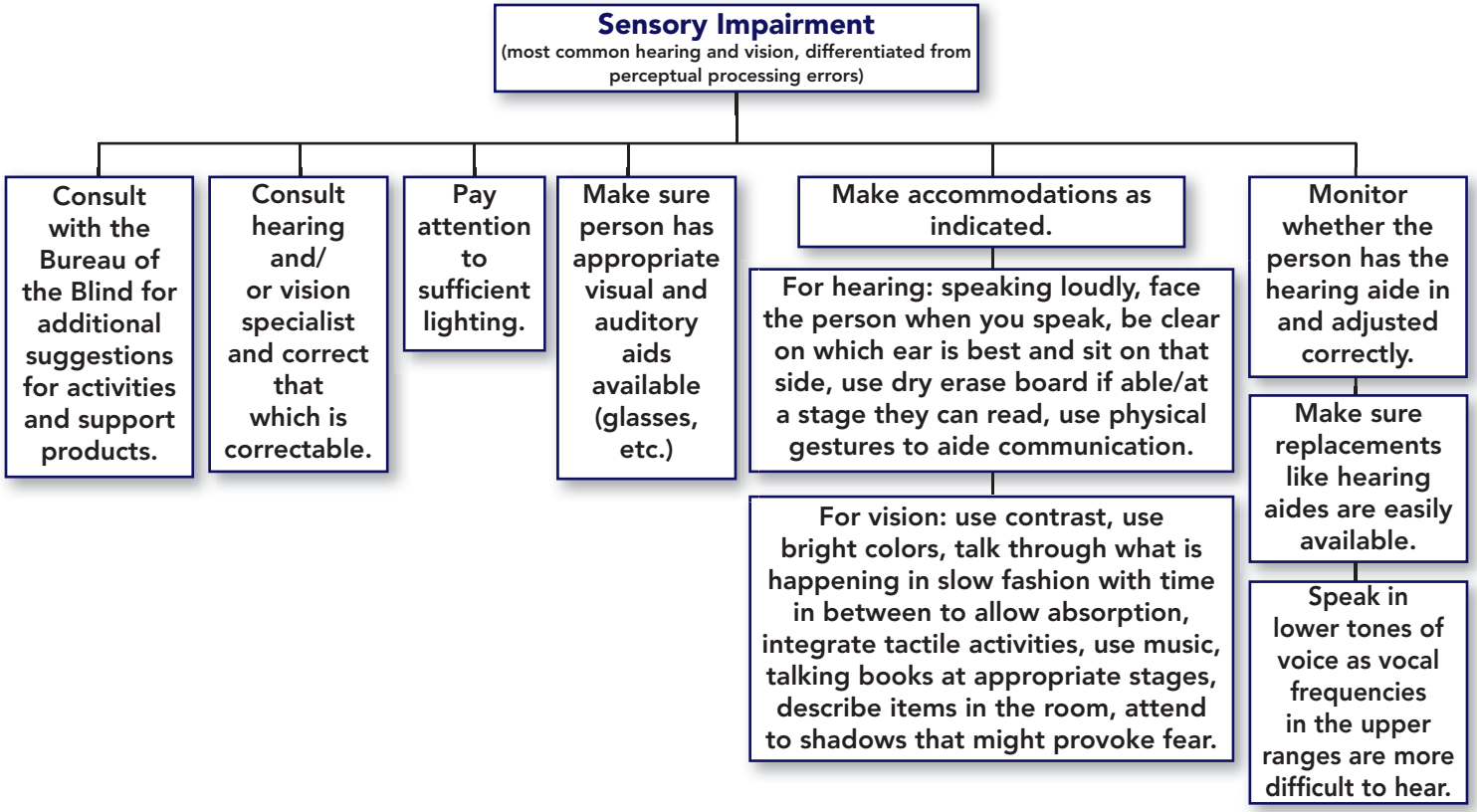
Next steps:
Complete a physical assessment. Know living will/DNR status. Consult physician and/or ambulance if indicated. Urinary Tract Infections are common and require urinalysis to both check and validate resolution. A person with progressed memory loss will be a poor reporter and may not be able to acknowledge discomfort or request a PRN. Provide comfort measures such as warm bath, repositioning, cushions, quiet environment. Be familiar with potential side effects of medication and monitor person. Monitor effect of medication and adjust as necessary per physician order.

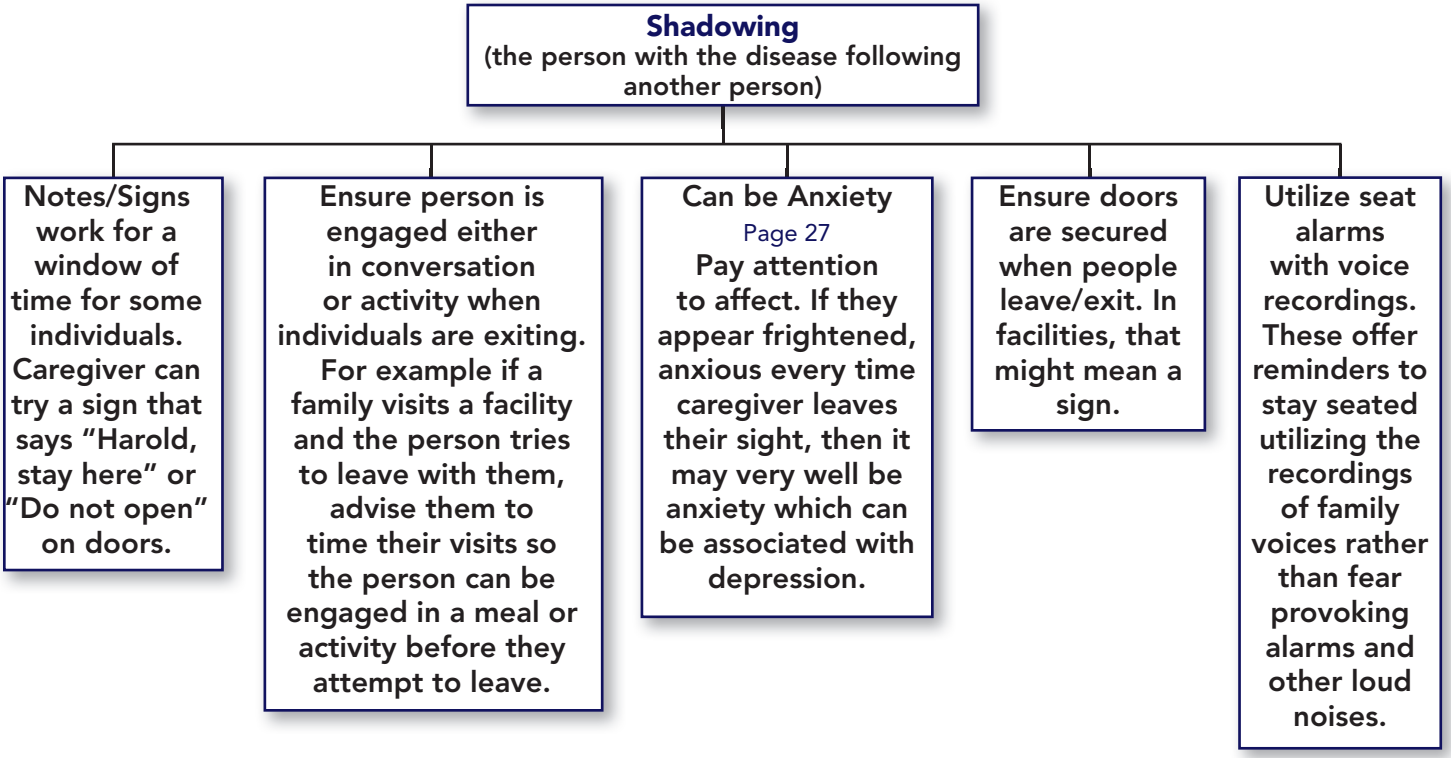
Chronic
(Back pain, sciatica, arthritis), peripheral neuropathy, restless leg syndrome, etc.)

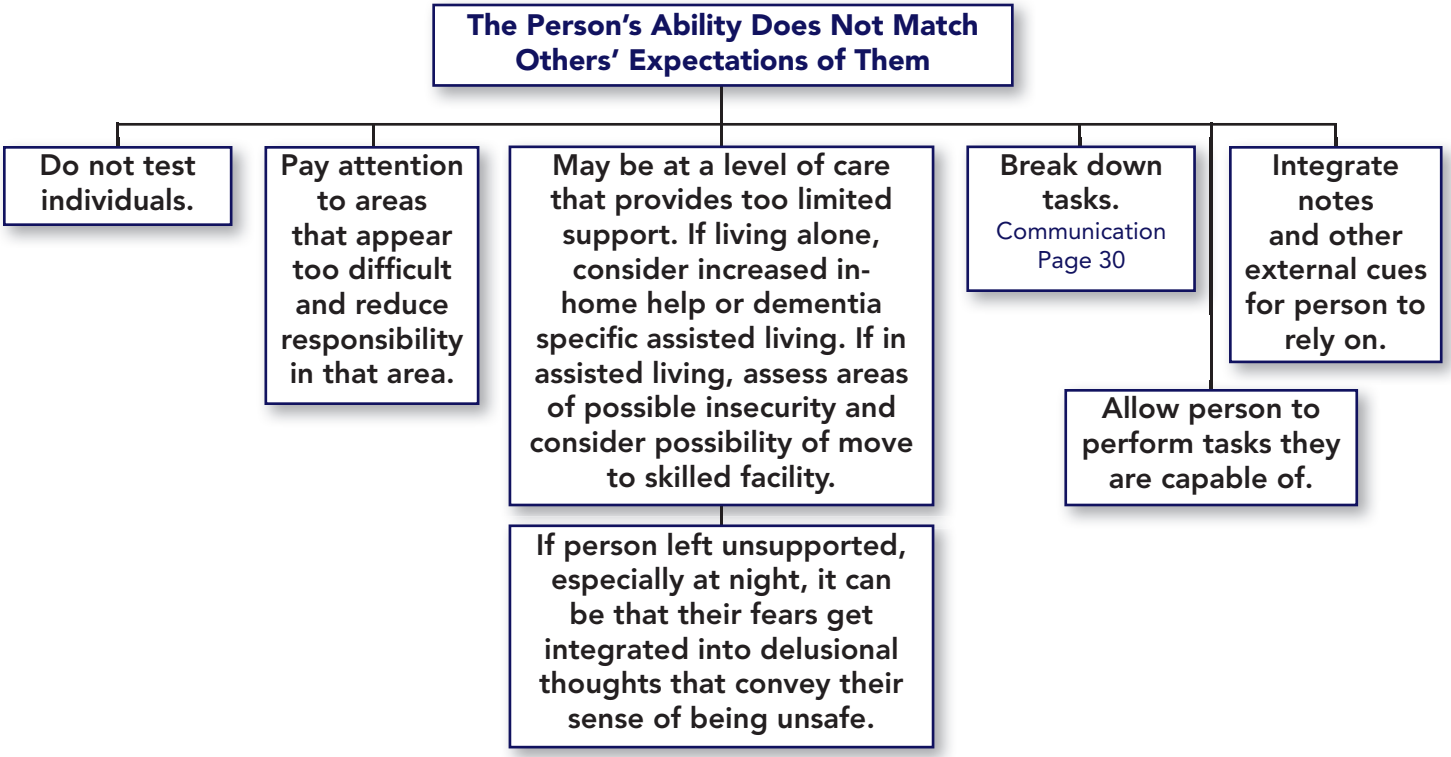
Possible indicators:
Worsening of behavior, refusal of fluids and food, increased irritability or increased drowsiness, grimacing, moaning or shouting, increased pacing, change in sleep pattern — including getting up/restlessness at night, tearfulness, withdrawal from others, changes in mood, changes in level of arousal, psychomotor agitation, legs in constant motion when in bed.

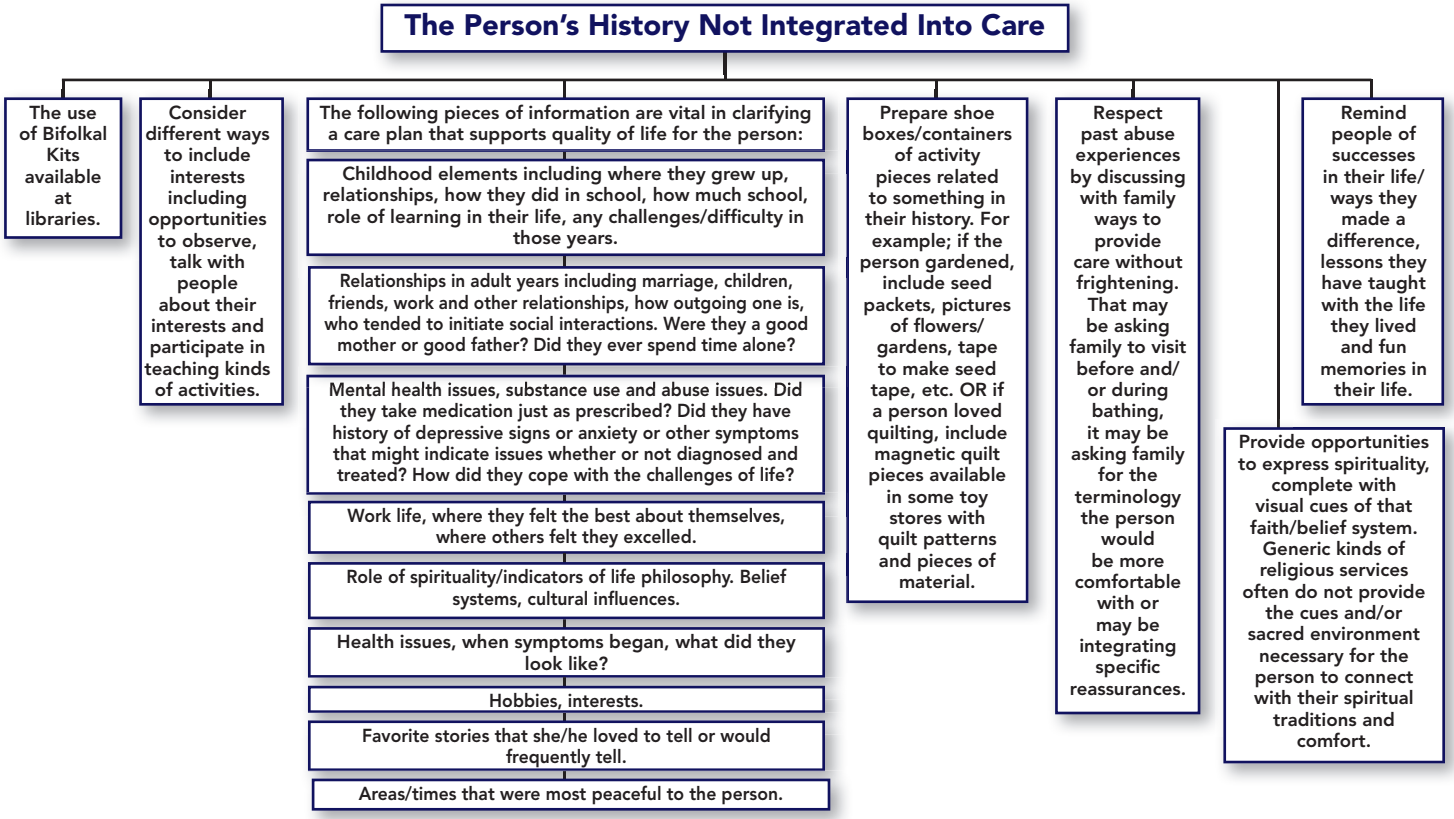
Next steps:
Review medical history for diseases causing chronic pain such as arthritis, neuropathy, etc. Check medication list to verify person is being treated for the condition. Complete physical assessment. Consult with physician for medication support. Recognize that the person will be a poor reporter and may not be able to acknowledge discomfort or request a PRN. Provide non medication treatment as warm bath, repositioning, specialized cushions, quiet environment. Be familiar with potential side effects of medication and monitor person. Monitor effect of medication and adjust as necessary per physician order. Attend to length of time in any one position/time sitting.


Psychosis
(Beliefs not based in reality or seeing/hearing/smelling/feeling something or someone no one else sees/hears/smells/feels)
Does the delusion (false belief) or hallucination provoke:
Distress for the person on a regular/continuing basis and cannot be reassured or diverted?
Interrupt ability to be cared for on a regular/continuing basis and cannot be reassured or diverted?
If no, go to communication. Page 30
Has the person retreated in their mind to a traumatic time in their life?
Reassure them they are safe and you will be there for them.
Rule out Urinary Tract Infection or other acute medical condition.
May require psychotropic support. Contact neurologist, geriatrician or geriatric psychiatrist.
Assess the environment. Is she/he seeing shadows or shapes of things that are being misperceived and provoking distress?
Look at the room in a way that they might. Remove potentially distressing objects if possible. If not, try to camouflage.
May be a separate visual problem. Sensory Impairment Page 51
Are they watching television shows/news that are disturbing or conveying negative emotion?
Be conscious of the television shows that are on. Perhaps put on a DVD of an old time variety or music program.
Are there family disagreements occurring in the presence of the person?
Arguments/family conflict should not be played out in front of the person with the disease. Nor should they be used as pawns in such disagreements. It is common for families to see things differently — encourage family meetings away from the individual with the disease to discuss issues with care, support and their grief.
Hotline case to APS if emotional abuse, financial exploitation or any other type of abuse is suspected.
Fear? Page 37
The person's ability does not match others' expectations of them. Page 53
Depression? Page 32
Has the person ever experienced psychosis before?
Assess for prior mental health changes.
Delirium? Page 31
Is anyone threatening the person physically or verbally?
Hotline the case to Adult Protective Services.


Sensory Impairment
(most common hearing and vision, differentiated from perceptual processing errors)
Consult with the Bureau of the Blind for additional suggestions for activities and support products.
Consult hearing and/ or vision specialist and correct that which is correctable.
Pay attention to sufficient lighting.
Make sure person has appropriate visual and auditory aids available (glasses, etc.)
Make accommodations as indicated.
For hearing: speaking loudly, face the person when you speak, be clear on which ear is best and sit on that side, use dry erase board if able/at a stage they can read, use physical gestures to aide communication.
For vision: use contrast, use bright colors, talk through what is happening in slow fashion with time in between to allow absorption, integrate tactile activities, use music, talking books at appropriate stages, describe items in the room, attend to shadows that might provoke fear.
Monitor whether the person has the hearing aide in and adjusted correctly.
Make sure replacements like hearing aides are easily available.
Speak in lower tones of voice as vocal frequencies in the upper ranges are more difficult to hear.


Shadowing
(the person with the disease following another person)
Notes/Signs work for a window of time for some individuals. Caregiver can try a sign that says "Harold, stay here" or "Do not open" on doors.
Ensure person is engaged either in conversation or activity when individuals are exiting. For example if a family visits a facility and the person tries to leave with them, advise them to time their visits so the person can be engaged in a meal or activity before they attempt to leave.
Can be Anxiety
Page 27
Pay attention to affect. If they appear frightened, anxious every time caregiver leaves their sight, then it may very well be anxiety which can be associated with depression.
Ensure doors are secured when people leave/exit. In facilities, that might mean a sign.
Utilize seat alarms with voice recordings. These offer reminders to stay seated utilizing the recordings of family voices rather than fear provoking alarms and other loud noises.


The Person's Ability Does Not Match Others' Expectations of Them
Do not test individuals.
Pay attention to areas that appear too difficult and reduce responsibility in that area.
May be at a level of care that provides too limited support. If living alone, consider increased in-home help or dementia specific assisted living. If in assisted living, assess areas of possible insecurity and consider possibility of move to skilled facility.
If person left unsupported, especially at night, it can be that their fears get integrated into delusional thoughts that convey their sense of being unsafe.
Break down tasks.
Communication Page 30
Allow person to perform tasks they are capable of.
Integrate notes and other external cues for person to rely on.


The Person's History Not Integrated Into Care
The use of Bifolkal Kits available at libraries.
Consider different ways to include interests including opportunities to observe, talk with people about their interests and participate in teaching kinds of activities.
The following pieces of information are vital in clarifying a care plan that supports quality of life for the person:
Childhood elements including where they grew up, relationships, how they did in school, how much school, role of learning in their life, any challenges/difficulty in those years.
Relationships in adult years including marriage, children, friends, work and other relationships, how outgoing one is, who tended to initiate social interactions. Were they a good mother or good father? Did they ever spend time alone?
Mental health issues, substance use and abuse issues. Did they take medication just as prescribed? Did they have history of depressive signs or anxiety or other symptoms that might indicate issues whether or not diagnosed and treated? How did they cope with the challenges of life?
Work life, where they felt the best about themselves, where others felt they excelled.
Role of spirituality/indicators of life philosophy. Belief systems, cultural influences.
Health issues, when symptoms began, what did they look like?
Hobbies, interests.
Favorite stories that she/he loved to tell or would frequently tell.
Areas/times that were most peaceful to the person.
Prepare shoe boxes/containers of activity pieces related to something in their history. For example; if the person gardened, include seed packets, pictures of flowers/gardens, tape to make seed tape, etc. OR if a person loved quilting, include magnetic quilt pieces available in some toy stores with quilt patterns and pieces of material.
Respect past abuse experiences by discussing with family ways to provide care without frightening. That may be asking family to visit before and/or during bathing, it may be asking family for the terminology the person would be more comfortable with or may be integrating specific reassurances.
Remind people of successes in their life/ways they made a difference, lessons they have taught with the life they lived and fun memories in their life.
Provide opportunities to express spirituality, complete with visual cues of that faith/belief system. Generic kinds of religious services often do not provide the cues and/or sacred environment necessary for the person to connect with their spiritual traditions and comfort.

Traumatic Adjustment to a New Environment

(Increased agitation occurring following environmental changes)

If in hospital

- Find ways to identify person as high risk for wandering, delirium and other issues for which a person with the disease is high risk. Possible places for identification: chart, utilizing specific colors for hospital ID band and naming specific protocols.
- Consider completing additional history with information re: day-to-day schedules, functional/behavioral patterns, as well as elements of life and history that can provide reassurance.
- Frequently reassure.
- Facilitate sleep: back massage, warm milk or herbal tea at bedtime; relaxation music/tapes; noise-reduction measures; avoid awakening the person unless vital.
- Foster familiarity: encourage family/friends to stay at bedside; bring familiar objects from home; maintain consistency of caregivers; minimize relocations.
- Incorporate hospital volunteers, if available, to assist with sitting/interacting with the patient.
- Educate family.
- Consider psychotropics as last resort.

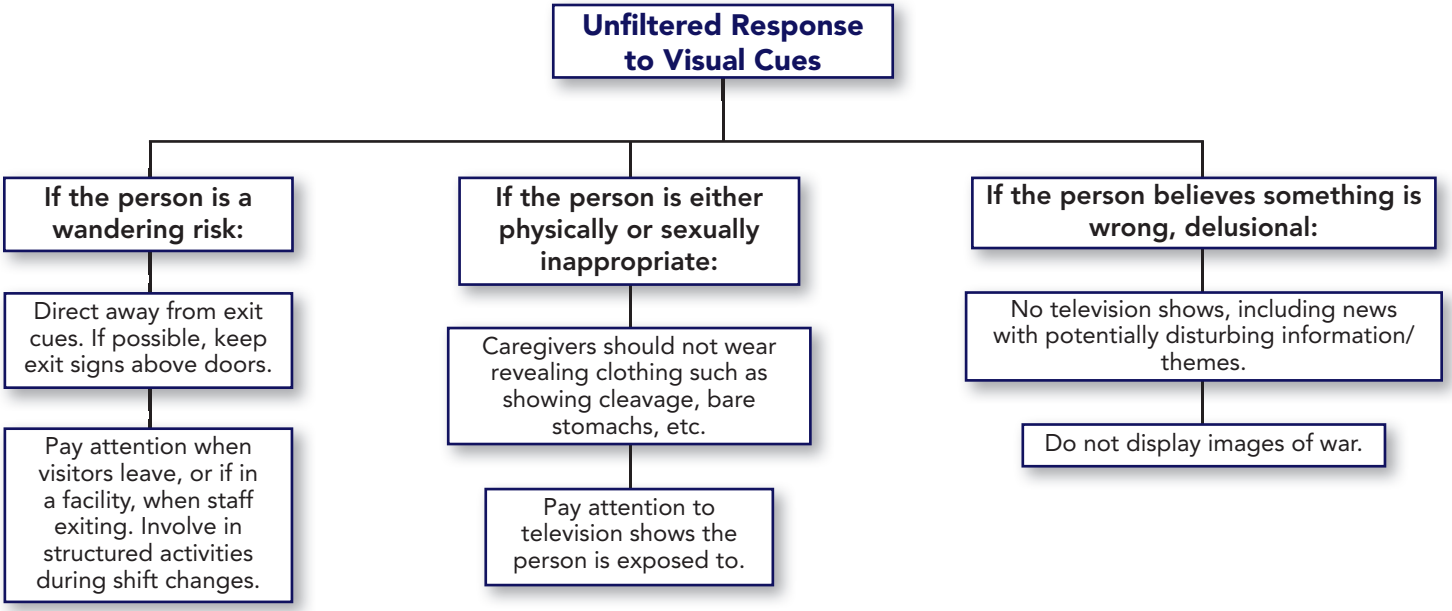
If in a long-term care facility

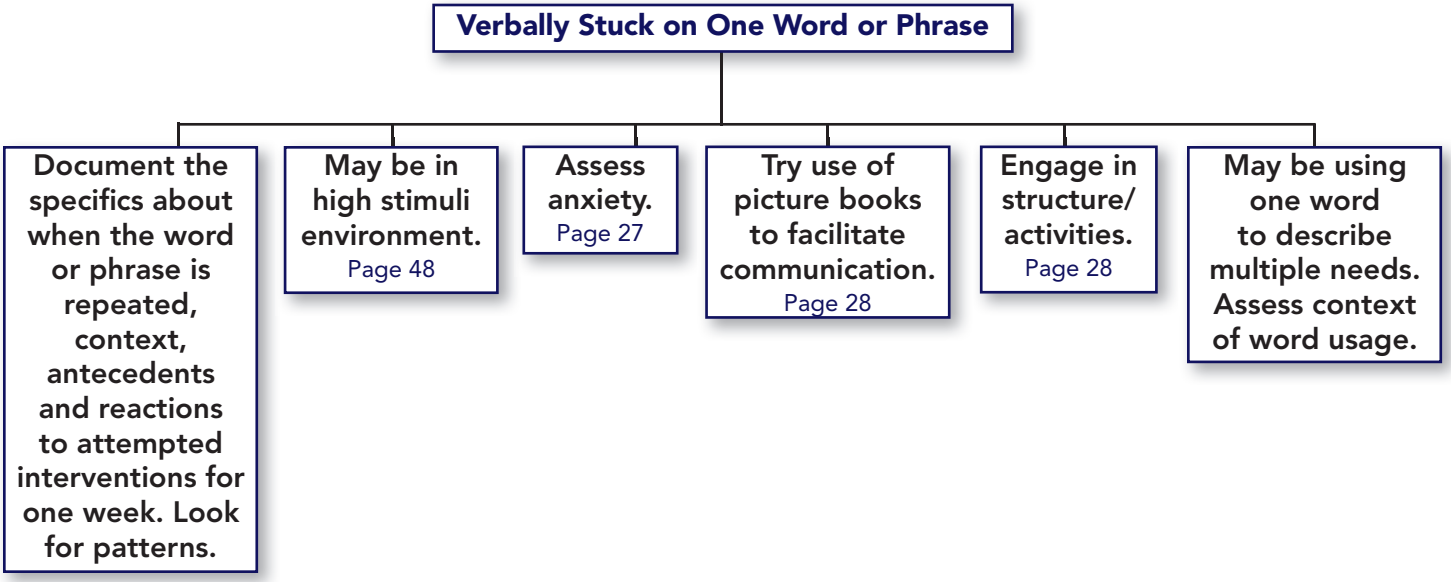
- Assign management staff member to a new resident and family for the first 2 weeks of individual's entry into the facility. Responsibilities for this assignment would be extra 1:1 time, supporting the resident in adjusting to new routine and to observe for ongoing needs and interventions to include in care plan.
- Instruct family to visit regularly and frequently, but to time visits so the resident is engaged in an activity or meal at point of their departure.
- Assess historical coping strategies and explore ways to adapt in current setting.
- Provide routine and structure.
- Know history and information re: day to day schedules, functional/behavioral patterns as well as elements of life and history that can provide reassurance.
- Consider incorporation of antidepressant and/or other psychotropic if sufficient trial of antidepressants and titration is unsuccessful.

If move to a family member's home

- Try to maintain elements of prior day to day structure.
- Encourage visitors, but one at a time.
- Provide frequent supportive and reassuring comments.
- Consider incorporation of antidepressant and/or other psychotropic if sufficient trial of antidepressants and titration is unsuccessful.

Pieces of above are from Tullmann DF, Mion LC, Fletcher K, Foreman MD. Delirium: prevention, early recognition, and treatment. In: Capezuti E, Swicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice, 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 111-25.


Unfiltered Response to Visual Cues
If the person is a wandering risk:
Direct away from exit cues. If possible, keep exit signs above doors.
Pay attention when visitors leave, or if in a facility, when staff exiting. Involve in structured activities during shift changes.
If the person is either physically or sexually inappropriate:
Caregivers should not wear revealing clothing such as showing cleavage, bare stomachs, etc.
Pay attention to television shows the person is exposed to.
If the person believes something is wrong, delusional:
No television shows, including news with potentially disturbing information/ themes.
Do not display images of war.


Verbally Stuck on One Word or Phrase
Document the specifics about when the word or phrase is repeated, context, antecedents and reactions to attempted interventions for one week. Look for patterns.
May be in high stimuli environment.
Page 48
Assess anxiety.
Page 27
Try use of picture books to facilitate communication.
Page 28
Engage in structure/ activities.
Page 28
May be using one word to describe multiple needs. Assess context of word usage.

Section IV

Resources, References and Reviewers

Resources and References

Managing Behavioral Symptoms of Residents with Dementia in the Long Term Setting; Richard Powers, M.D.; Dementia Education and Training Program for the State of Alabama, Bureau of Geriatric Psychiatry; 2008
www.alzbrain.org

A Short Practical Guide for Psychotropic Medications in Dementia Patients; Richard Powers, M.D.; Dementia Education and Training Program for the State of Alabama, Bureau of Geriatric Psychiatry; 2008
www.alzbrain.org

Lyketos, C., Lopez, O., Jones, B., Fitzpatrick, A., Breitner, J., DeKosky, S.; "Prevalence of Neuropsychiatric Symptoms in Dementia and Mild Cognitive Impairment"; *Journal of the American Medical Association*; September 25, 2002; Volume 288, No. 12, p. 1475-1483

Pollack, B, Mulsant, B, Rosen, J., Mazumdar, S., Blakesly, R., Houck, P., Huber, K.; "A Double-Blind Comparison of Citalopam and Risperidone for the Treatment of Behavioral and Psychotic Symptoms Associated with Dementia"; *American Journal of Geriatric Psychiatry*; November 2007; 15:11; p. 942-952

Silverstein, N., Maslow, K. editors; *Improving Hospital Care for Persons with Dementia*; Springer Publishing; 2006; New York, New York

Kelsey, S., Laditka, S., Laditka, J.; "Transitioning Dementia Residents from Assisted Living to Memory Care Units: A Pilot Study"; *American Journal of Alzheimer's Disease*; August/September 2008; Volume 23: Number 4; p. 355-362

Mittelman, M., Roth, D., Coon, D., Haley, W.; "Sustained Benefit of Supportive Intervention for Depressive Symptoms in Caregivers of Patients with Alzheimer's Disease"; *American Journal of Psychiatry*; May 2004; Volume 161, No. 5; p. 850-856

Bass, D., Clark, P., Looman, W., McCarthy, C. Eckert, S.; "The Cleveland Alzheimer's Managed Care Demonstration: Outcomes After 12 Months of Implementation"; *The Gerontologist*; Feb. 2003; Volume 43, Number 1; p. 73-85

Cherry, D., Vickrey, B., Schwankovsky, L., Heck, E., Plauche, M., Yep, R.; Interventions to Improve Quality of Care: The Kaiser Permanente-Alzheimer's Association Dementia Care Project"; *The American Journal of Managed Care*; August 2004; Volume 10, Number 8; p. 553-560

Vickrey, B., Mittman, B., Connor, K., Pearson, M., Della-Penna, R., Ganiats, T., DeMonte, R., Chodosh, J., Cui, X., Vassar, S.; "The Effect of a Disease Management Intervention on Quality and Outcomes of Dementia Care"; *Annals of Internal Medicine*; November 2006; Volume 145, Number 10; p.713-725

Teri, L., McCurry, S., Logsdon, R., Gibbons, L.; "Training Community Consultants to Help Family Members Improve Dementia Care: A Randomized Controlled Trial"; *The Gerontologist*; 2005; Volume 45, Number 6, p. 802-811

Logsdon, R., McCurry, S., Teri, L.; "STAR-Caregivers: A Community Based Approach for Teaching Family Caregivers to Use Behavioral Strategies to Reduce Affective Disturbances in Persons with Dementia"; *Alzheimer's Care Quarterly*; April/June 2005; Volume 6, Number 2; p.. 146-153

Gonyea, J., O'Connor, M., Boyle, P.; "Project CARE: A Randomized Controlled Trial of a Behavioral Intervention Group for Alzheimer's Disease Caregivers"; *The Gerontologist*; December 2006; Volume 46, Number 6, p. 827-832

When a Family Member has a Dementia: Steps to Becoming a Resilient Caregiver; McCurry, Susan; Praeger Publishers; Westport, CT; 2006

Delirium: The Mistaken Confusion; Cason-McNeeley, Debra; Pesi Healthcare, Eau Claire, Wisconsin, 2004

Pallative Care for Advanced Alzheimer's and Dementia: Guidelines and Standards for Evidence Based Care; Martin, Gary and Sabbagh, Marwan, Editors; Springer Publishing; New York, New York, 2011

"*He's doing this to spite me*" DVD; Northwest Media;1999

Robinson A, Spencer B, White L. 1989. Understanding difficult behaviors. Eastern Michigan University: Ypsilanti, MI.

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Section V

Alzheimer's Association Information

The Alzheimer's Association is the leading, global voluntary health organization in Alzheimer's care and support, and the largest private, nonprofit funder of Alzheimer's research. Our vision is a world without Alzheimer's , and since our founding in 1980, we have moved toward this goal by advancing research and providing support, information and education to those affected by Alzheimer's and related dementias.

There are many chapters of the Alzheimer's Association throughout the United States. The Heart of America Chapter serves 66 counties including 29 in Missouri and 37 in Kansas. The Chapter offers a variety of services including support groups, family consultations both in the home and in each of the five regional offices, a 24-hour information and support line, early stage programs, educational materials and programs as well as advocacy efforts for all those who are directly impacted by Alzheimer's disease and related dementias. The Chapter also has dementia crisis support coordinators who participate in the quest to figure out the elements of neuropsychiatric challenges, problem solve possible interventions and to support the individual, family and the professionals working through these difficult elements of the disease.

For more information contact:
1.800.272.3900 or 913.831.3888

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Index