

## Alzheimer's disease

# Managing behavioral problems in patients with progressive dementia

Gene D. Cohen, MD, PhD, Series Editor

### Case presentation

An older married couple—Mr. and Mrs. T—came to the geriatrician's office because Mrs. T, age 78, was complaining that Mr. T, age 82, had become agitated, angry, and accusatory towards her. Mrs. T was fatigued and depressed by her husband's behavior and was seeking treatment for him. Mr. T was not sure why he was in the doctor's office, but said he came because his wife insisted.

Mr. T had difficulty providing a medical history because he had severe memory problems and was unable to respond to the questions being asked. He appeared restless and annoyed throughout the interview. Four years earlier, Mr. T was diagnosed with Alzheimer's disease (AD) and had been living at home with his wife since then. In addition to AD, for which donepezil, 5 mg bid, had been prescribed, Mr. T had high blood pressure managed by an antihypertensive medication, hearing loss improved by a hearing aid, and myopia alleviated by prescription eye glasses. He was otherwise in remarkably good health. Physical examination revealed no new problems. Blood studies (ie, CBC, electrolyte, liver and kidney function, cardiac enzyme, and thyroid func-

**Dr. Cohen**, a geriatric psychiatrist, is director of the Center on Aging, Health, & Humanities at George Washington University, Washington, DC, where he is professor of health care sciences and professor of psychiatry and behavioral sciences.

### Table 1 Clinical questions to answer when managing behavioral problems in AD

1. Is pharmacologic intervention indicated? If so, what symptom should be targeted (eg, delusions, depression, anxiety, etc.)?
2. What behavioral and psychosocial interventions could:
  - make the patient's environment less challenging (eg, written reminders, night lights leading to the bathroom, etc.)?
  - provide structured activities the patient can perform and finds satisfying?
3. Which community services can provide supportive, structured, and supervised activities (eg, day programs, home care aides)?
4. What interventions and supportive programs could reduce the family caregiver's burden and emotional strain?

Source: Prepared for Geriatrics by Gene D. Cohen, MD, PhD

tion tests) were normal. Chest films and urine analysis also were normal.

Before being diagnosed with AD, Mr. T volunteered at the local library, helping to catalogue and sort books. He had continued this volunteer work until 6 months prior to his office visit. The work, coupled with mistakes he was making, made him increasingly frustrated, to the point where he quit and confined his activities to the home.

He required considerable attention and supervision, so his wife hired a homemaker. Mr. T resented the homemaker and accused her of stealing some of his possessions, although there was no evidence that any theft had occurred. Mr. T also accused his wife of having an affair whenever she would leave the house to go shopping. He became angry and agitated at these times, and Mrs. T feared that he would become violent. She was also concerned that the homemaker would quit, so Mrs. T

brought her husband to the geriatrician.

### Resolution

The doctor determined that Mr. T's dementia had progressed significantly, to the point where he was having difficulty coping with everyday tasks. He was delusional with paranoid concerns that the homemaker was stealing and that his wife was being unfaithful. The doctor was concerned that Mr. T's behavior had caused his wife to become exhausted and depressed.

The doctor did not challenge Mr. T's delusions and focused instead on the discomfort Mr. T was feeling. The doctor was concerned about Mr. T's stress and said he wanted to prescribe a medication to relieve it. Mr. T responded positively to the doctor's concern and agreed to take the medication. The doctor added risperidone, 0.5 mg at bedtime, to Mr. T's medication regimen and sched-

uled a follow-up appointment for Mr. T in 6 weeks, at which time he planned to reevaluate the risperidone dose.

The doctor also explained the importance of providing Mr. T with structured, meaningful time away from home during which he could perform activities suited to his abilities. Mrs. T was given the phone number of a local agency that sponsored a day program for adults with cognitive impairment. The doctor suggested that she explore the program, but wait 1 to 2 weeks for the medicine to begin working before she took Mr. T for a visit. The program would provide structured time and allow Mr. T to channel his energy more constructively. It would also give Mrs. T some respite. The doctor gave Mrs. T the phone number of a local support group for caregivers of AD patients and told her they could provide emotional support and valuable information about managing everyday issues.

## Discussion

Alzheimer's disease is progressive and cannot be halted or reversed, yet some interventions can alleviate suffering, improve coping, and enhance patients' dignity as they live with the disorder. By answering the four clinical questions in table 1, physicians can help patients and families deal with behavioral problems that accompany AD. During the course of the disease, most AD patients experience depression and agitation, the latter often provoked by delusions or an unstructured environment.

The added difficulty caused by these behavioral problems is called excess disability, which means the patient functions more poorly than he would with cognitive impairment alone. Excess disability can often be alleviated by the judicious use of medications (eg, Mr. T's delusions were treated with one of the newer atypical neuroleptics). It can also be reduced by behavioral and psychosocial management, which may include having patients participate in meaningful activities that

**Table 2 Common medications used for treating psychosis in AD\***

Medication	Dose range
<b>Typical neuroleptics</b>	
Haloperidol (Haldol)	0.25 to 2 mg/d
Perphenazine (Trilafon)	2 to 8 mg/d
Thioridazine HCl (Mellaril)	10 to 100 mg/d
<b>Atypical neuroleptics</b>	
Olanzapine (Zyprexa)	2.5 to 15 mg/d
Quetiapine fumarate (Seroquel)	25 to 100 mg/d
Risperidone (Risperdal)	0.25 to 2 mg/d

\*Because they have fewer side effects, the newer atypical neuroleptics have generally replaced the older typical neuroleptics for the treatment of psychotic symptoms associated with AD.

Source: Adapted by Gene D. Cohen, MD, PhD, from Salzman, 2001

**Table 3 Toll-free Alzheimer's disease assistance phone numbers**

### For families

The Alzheimer's Association: 1-800-272-3900

- Provides educational literature for families
- Can link a family with a local Alzheimer's disease support group

Elder Care Locator: 1-800-677-1116

- Can identify the nearest Area Agency on Aging, which in turn identifies local resources and services for older adults
- Useful for adult children who need to find services for parents living some distance away


### For physicians

The Alzheimer's Disease Education and Referral Center (ADEAR): 1-800-438-4380

- Offers no-cost searches of the scientific literature on AD and sends annotated bibliographies
- Identifies locations of Alzheimer's Disease Research Centers for patients who want to participate as research subjects

Source: Prepared for Geriatrics by Gene D. Cohen, MD, PhD

are structured and supervised, such as those provided by an adult day treatment program.

Although pharmacologic agents for managing memory and cognitive problems provide limited benefit, much can be done to treat the range of behavioral problems that accompany AD (table 2). Support programs can help caregivers manage burden and stress, which can place them at increased risk for physical and mental health problems. Table 3 lists toll-free numbers of organizations that provide helpful information for families and physicians. 

## Bibliography

- Cohen GD. Management of Alzheimer's disease. *Adv Intern Med* 1995; 40:31-67.
- Finkel SI, Burns A, Cohen GD. Overview, behavioral and psychological symptoms of dementia (BPSD): A clinical and research update. *Int Psychogeriatr* 2000; 12(S1):13-18.
- Radebaugh TS, Buckholz N, Khachaturian Z (guest eds). Behavioral approaches to the treatment of Alzheimer's disease: Research strategies. *Int Psychogeriatr* 1996; 8(S1):1-144.
- Salzman C. *Psychiatric medications for older adults*. New York: The Guilford Press, 2001:113.