Chapter 1

Behavioural and Psychological Symptoms in Dementia (BPSD)

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ABSTRACT

Behavioural and Psychological Symptoms in Dementia (BPSD) is a term that embraces a heterogeneous group of non-cognitive symptoms and behaviours that occur in people with dementia. The development of BPSD is associated with a worse prognosis and a more rapid rate of illness progression and adds significantly to the direct and indirect costs of care. Challenges in dealing with BPSD can be manifold and impacts significantly on patients, carers and service providers. The aim of this chapter is to provide an overview of commonly encountered BPSD and the challenges posed to carers and service providers in its management, with a particular focus on emerging technology to help deal with these challenges effectively. We attempt to consider the issues involved from the viewpoint of patients, carers and service providers.

INTRODUCTION

Behavioural and psychological symptoms in dementia (BPSD) is an umbrella term that embraces a heterogeneous group of non-cognitive symptoms and behaviours that occur in people with dementia. BPSD can be defined as symptoms of disturbed perception, thought content, mood or behaviour, frequently occurring in patients with dementia. Most of these symptoms and behaviours do not occur in isolation but tend to occur together in clusters or syndromes. The development of BPSD is a major risk factor for caregiver burden (Coen et al, 1997) and institutionalisation (O’Donnell et al, 1992) Both depression and psychosis are included as descriptors in the DSM-IV criteria for Alzheimer’s disease (American Psychiatric Association, 1994) and, more recently, diagnostic criteria for a distinct syndrome of psychosis of Alzheimer’s disease and related dementias and for depression of Alzheimer’s disease have been proposed (Jeste & Finkel, 2000; Olin et al, 2002).
The development of BPSD is also associated with a worse prognosis and a more rapid rate of illness progression (Paulsen et al, 2000), and adds significantly to the direct and indirect costs of care.

BPSD of varying degrees of severity are present in more than 80% of patients with dementia. In about 33% of community-dwelling people with dementia the level of BPSD will be in the clinically significant range (Lyketsos et al, 2000). This figure rises to almost 80% for people with dementia who reside in care environments (Margallo-Lana et al, 2001). Two population-based studies, one from the USA (Lyketsos et al, 2000) and one from the UK (Burns et al, 1990), show similar prevalence figures of about 20% for BPSD in people with Alzheimer’s type dementia, which is the commonest form of dementia seen in general population.

The more commonly seen presentations of BPSD are anxiety, depression, hallucinations and delusions, psychomotor agitation, aggression, wandering, screaming, shouting, biting, spitting, sexually inappropriate behaviour, sleep disturbances, personality change, repetitive vocalisation, apathy and other non-specific behaviours. BPSD tend to be worse late afternoons and this phenomenon is often referred to as “sun downing”.

The symptoms can vary according to the stage of the illness, pre-morbid personality, environmental and social factors.

Certain symptom clusters are associated with specific types of dementia. For example, visual hallucinations are more common in Lewy Body Dementia and Parkinson’s Disease. Dementia while people suffering from Frontotemporal dementia are more likely to have personality changes and socially and sexually inappropriate behaviours. A similar picture is seen in people suffering from Huntington’s Disease. Troublesome and disruptive behaviours have been reported to occur earlier and more frequently in Huntington’s chorea and Creutzfeldt-Jakob disease (Cummings and Duchen, 1981).

Anxiety can be more common in the initial stages though at times, people do experience intense periods of anxiety in later stages. Anxiety can manifest as restlessness, panicky feelings, palpitations, sweaty palms, choking sensation, chest pains, headaches, light headedness and dizziness.

Depression can be present in all the stages of dementia. Depression can present as low mood, tearfulness, lack of motivation, lack of energy, suicidal ideations, feelings of hopelessness and worthlessness, loss of appetite, sleep disturbances and inability to enjoy normal activities. There is increased risk of self-harm in these patients.

Hallucinations are abnormal sensory experiences in the absence of real or actual stimuli. They can take the form of visual, auditory, olfactory, tactile and gustatory sensations and can cause significant distress to patients. Visual and auditory hallucinations are more common in dementia. Estimates of the frequency of hallucinations in people with dementia range from 12% to 49% (Swearer, 1994). Visual hallucinations are common, occurring in up to 30% of patients with dementia and these are more common in moderate than in mild or severe dementia (Swearer, 1994). Visual hallucinations can present with seeing people, deceased relatives, children and animals around them. Sometimes, these can be in the form of shadows, shapes and poorly formed structures while at other times the images are more distinct and well formed.

Auditory hallucinations present as hearing voices either talking to patients directly or about them. This can be in the form of running commentary on the sufferer’s actions or persecutory and derogatory in content. They can also be in the form of simple sounds or more complex pieces of music. Up to 10% of patients with dementia may also have auditory hallucinations at any time in their illness but other types such as those of an olfactory or tactile nature are rare (Swearer, 1994).

Delusions are abnormal thought process which present as false, firmly held beliefs which are not in keeping with a person’s social and cul-