The CLINICAL VIEW

Geriatric Psychiatry in Long-Term Care

AAGP American Association for Geriatric Psychiatry

APRIL 2004
VOL. 2, ISSUE 2

Sponsored by
The American Association for Geriatric Psychiatry

INSIDE THIS ISSUE:

Page 5
The Screamer

Page 8
Sexual Disinhibition and Aggression in the Nursing Home Setting

Page 11
Wandering Behavior Staying Safe—A Practical Guide

PAGE 14
CME Self-Assessment Test—Screaming, Groping, and Wandering in the Nursing Home Setting

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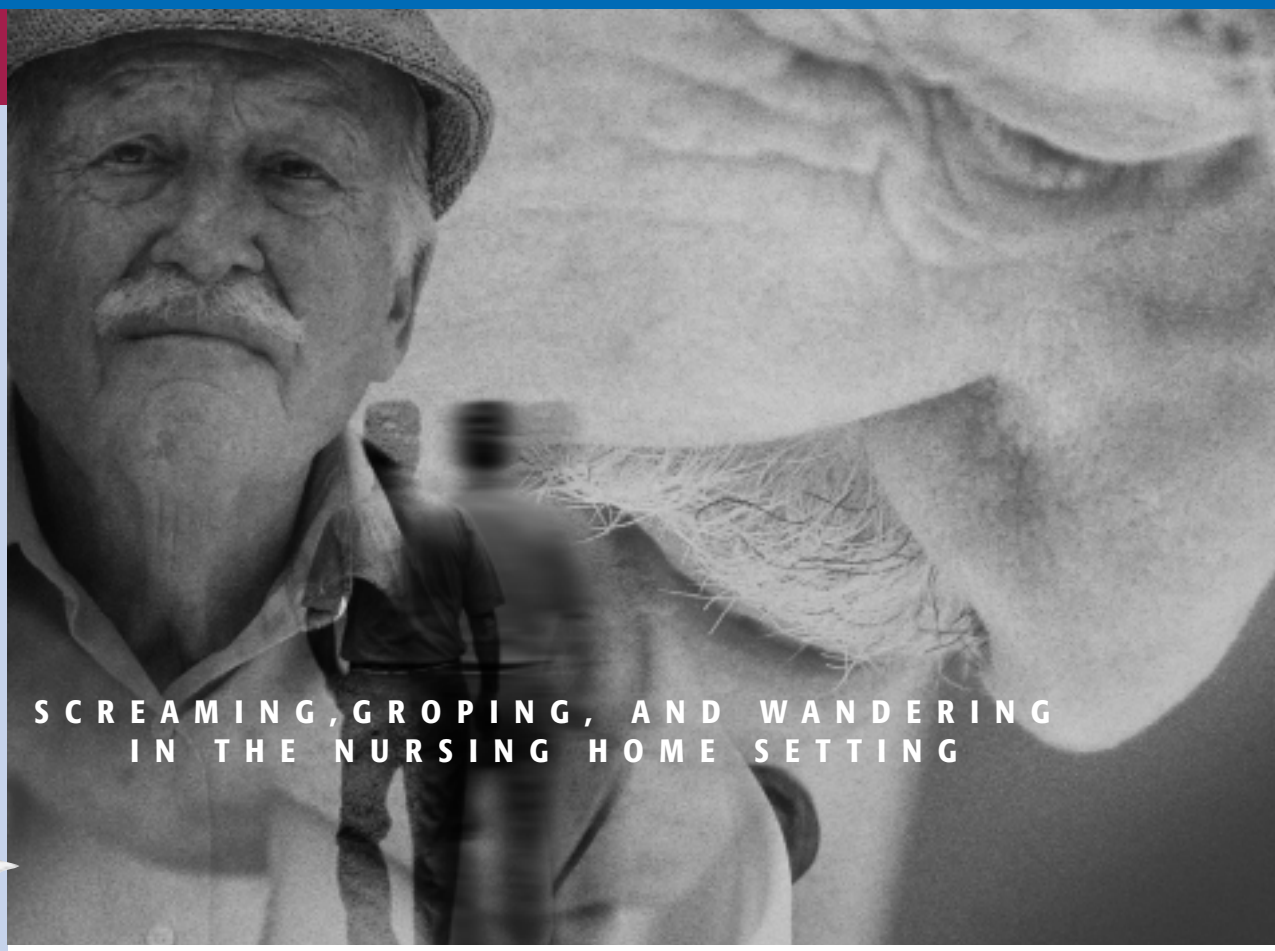

SCREAMING, GROPING, AND WANDERING IN THE NURSING HOME SETTING

INTRODUCTION

By Gary S. Moak, M.D., Editor-in-Chief

Patients who wander intrusively, seek egress, scream continuously, refuse to eat or drink, resist care, throw themselves on the floor, scratch or pick holes in themselves, or are sexually aggressive often require intervention to prevent harm to themselves or others.

Nursing home psychiatrists frequently are asked to see such distressing patients in the hope that medication can be given to alleviate the problem behavior. Such behavioral problems do not readily fit into diagnostic categories for which there are pharmacologic treatments with FDA-approved indications, and "off-label" prescribing is the expected norm. Experienced geriatric psychiatrists, however, recognize the limitations of pharmacotherapy, and in many cases may prefer to recommend behavioral or environmental interventions. Long-term care consultants

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Volume 2, Issue 2, April 2004

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Author Disclosures

The American Association for Geriatric Psychiatry requires that the authors participating in a continuing medical education activity disclose to participants any significant financial interest or other relationship (1) with the manufacturer of any commercial services discussed in an education presentation, and (2) with any commercial supporters of the activity. The authors reported the following:

David S. Harnett, M.D.—Reported no actual or potential conflict of interest in relation to this educational activity.

Douglas A. Kalunian, M.D.—Reported being on the speaker's bureau of Pfizer, Forest, and Novartis.

Alan Steinberg, M.D.—Reported being on the speaker's bureau of Abbott, Forest, GlaxoSmithKline, Janssen, Lilly, Novartis, and Pfizer.

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Educational Grant

This activity is supported by an educational grant from AstraZeneca Pharmaceuticals LP.

Intended Audience

This activity is intended for psychiatrists.
Release date: April 2004
Expiration date: April 2005

Learning Objectives

Upon completion of this activity, participants should be able to:

- Discuss the multi-factorial components that contribute to wandering.
- Compare treatment options for wandering.
- Describe a variety of behavioral and environmental strategies to prevent wandering.
- Discuss the role of staff and family in developing goals to work with sexually disinhibited residents.
- Cite possible causes of sexual disinhibition.
- Describe behavioral interventions that may decrease sexual disinhibition.
- Explain the advantages and disadvantages of pharmacologic interventions for sexual disinhibition.
- List factors that cause screaming.
- Discuss the initial assessment for screaming.
- Select appropriate therapeutic options to alleviate screaming.

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Introduction (continued from page 1)

should individualize their recommendations based upon comprehensive assessment of the patient, environment, and caregivers.

This issue of *The Clinical View* contains articles about three specific behavioral syndromes: sexually aggressive behavior, screaming, and wandering. Each represents a different form of agitation, a descriptively heterogeneous construct. The syndromes discussed in this issue, as well as the others mentioned above, nonetheless share certain common features: they create risk of harm, stress caregivers who come to feel angry over the purposeful quality of the behavior, and they often defy a simple, unitary approach to treatment. Experienced nursing home psychiatrists recognize that published practice guidelines say little about specific behavioral syndromes and most practice in this area is ahead of scientific evidence.

The syndromes discussed in this issue share certain common features: they create risk of harm, stress caregivers who come to feel angry over the purposeful quality of the behavior, and they often defy a simple, unitary approach to treatment.

Notwithstanding such limitations, readers will glean a number of common principles from the articles contributed herein by Drs. Steinberg, Harnett, and Kalunian. First, comprehensive neuropsychiatric assessment must include careful behavioral description, including environmental contingencies. Second, even when a behavioral explanation seems apparent, thorough medical and nursing assessments are essential to identify physical factors that may be as much the cause of the disturbed behavior. Third, consulting psychiatrists must be skilled in a range of interventions both pharmacologic and non-pharmacologic. Finally, psychiatrists must be prepared to work with caregivers to ensure effective implementation of treatment. Obviously, it is essential to possess knowledge of all applicable regulatory agency policies affecting the use of restraints and *p.r.n.* medications for agitation in long-term care settings.

Effective consultation services for patients with difficult behavior is time intensive. Readers familiar with the woeful state of Medicare reimbursement for mental health services in long-term care might justifiably wonder whether conscientious practitioners can provide the complex services needed while maintaining a viable long-term care consulting practice. If you have such concerns, watch for the next issue of *The Clinical View*, which will cover practice management considerations for financially viable long-term care practice.

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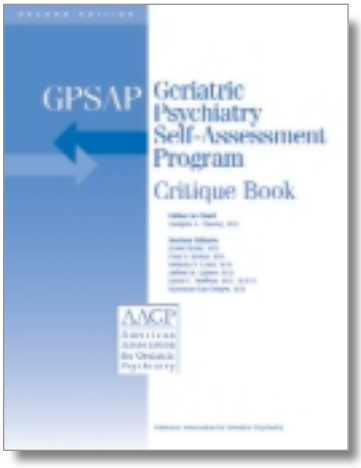

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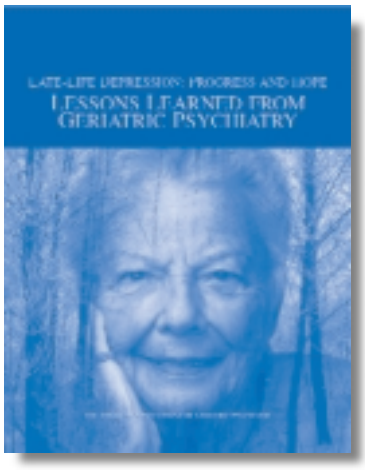

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THE SCREAMER

By Alan L. Steinberg, M.D.

> *"I was walking along the road with two friends.*
> *The sun was setting.*
> *I felt a breath of melancholy –*
> *Suddenly the sky turned blood-red.*
> *I stopped, and leaned against the railing, deathly tired –*
> *looking out across the flaming clouds that hung like blood*
> *and a sword*
> *over the blue-black fjord and town.*
> *My friends walked on – I stood there, trembling with fear.*
> *And I sensed a great, infinite scream pass through nature."*
> ***–Edvard Munch***

What must it be like for the victim of dementia who is scared, feels alone and afraid? What if they are hurting, and cannot express themselves to us? Are they, like Munch, "trembling with fear," with nothing left available to them but "a great infinite scream"? Paintings such as Munch's *The Scream* depict not so much an event or a place as a state of mind. It is the state of mind of the patient who screams that this article will address. In understanding that state of mind we may come closer to being of assistance to our patients and their caregivers.

In the long-term care setting, we clinicians are often faced with a bewildering array of clinical symptoms exhibited by patients. A majority of these are patients experiencing dementia. We must attempt to identify causes of their symptoms and provide appropriate remedies. One of the most common and challenging clinical scenarios is that of the resident who is verbally agitated and whose screaming is anguishing to the patient and to the staff, and disruptive to others.

Mrs. Jones is an 83-year-old woman with severe dementia, who has been living on a dementia unit in a nursing home for the past three years. Generally calm and cooperative, for the past month she has been increasingly restless, with psycho-motor agitation and bursts of screaming, with a crescendo-decrescendo pattern. No words are expressed and she can be only briefly redirected with one-on-one attention. The families of other residents have started to complain about her, and the staff are becoming increasingly frustrated by their inability to soothe her. The screaming occurs both during the day and at night without any clear pattern identified.

This is a fairly typical clinical scenario witnessed every day in thousands of nursing homes and assisted-living facilities across the nation. In a study done in 1990, Cohen-Mansfield found that 15 percent of nursing home residents were "frequent screamers."[1] Others have found that two percent are constant screamers.[2] According to the International Psychogeriatric Association Task Force on Behavioral and Psychological Symptoms of Dementia, 33 percent of patients with dementia have verbal outbursts. Clinicians who devote a portion of their careers in the long-term care setting probably would find that these numbers underestimate the true incidence of verbal disruptions.

Screaming has an impact on both the patients and the staff of facilities. The impact on the staff can be significant. If insomnia is "the straw that breaks the camel's back" when it comes to a family's decision to place a loved one in the nursing home, it is screaming which is often the "last straw" for the nursing home staff. This is a behavior that taxes even the most committed staff members and often will lead to inappropriate use of medications, restraints, and psychiatric hospitalization.

As in any investigation of behavioral symptoms in dementia, it is important to remember that many symptoms can be the result of multiple causes. Therefore it is appropriate to develop a clinical paradigm of investigation that is concise and easily applicable when screaming occurs. Screaming specifically is the result of environmental, circumstantial, physical, and psychiatric causes. Examples of environmental causes include over-stimulation, or even its opposite, boredom. Pain, hunger, fearfulness, and depression are also common causes of verbal agitation.

Any approach to screaming should include an accurate description of the behavior itself. For instance, is the screaming done in anger? Is there paranoia expressed during the outbursts? Does it only occur at certain times, such as when being bathed or fed? Is it worse as twilight approaches? Each of these circumstances may provide clues to the underlying cause, and therefore lead to a rational treatment approach.

Mrs. Stone is a 75-year-old woman with Alzheimer-type dementia who was recently admitted to the nursing home. Her admission medications included both an antidepressant and an atypical neuroleptic. Her family described periods of agitation, screaming, and sleeplessness prior to the medication. For the first week following her admission she was calm and cooperative and did not exhibit any symptoms of agitation. However, starting the second week, her restlessness and agitation increased, with recurrent loud outbursts, which were not redirectable. Her family reported that these were symptoms similar to those that led to medicating Mrs. Stone while she was an outpatient.

In assessing the individual with verbal agitation, the initial and foremost issue is to identify any underlying medical conditions that may be directly or indirectly causing the behavior. A full work-up should be done and should include a complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid function tests (TFT), vitamin B12 assay, and urine culture and sensitivity (C&S). If there are any signs of an upper respiratory infection, consideration should be given to obtaining a chest X-ray. If there have been any falls, and especially if the patient is on any type of anticoagulant, consideration should be given to obtaining a CT scan to rule out a subdural hematoma. Identification and treatment of an underlying dehydration, hypoglycemia, hyperthyroidism, or most commonly, a urine infection, can often lead to resolution of the screaming. In the case of Mrs. Stone, the initial predilection of the internist was to increase the dosage of the neuroleptic, but testing revealed a urinary tract infection. Antibiotic treatment resolved the agitation, and no further increases in psychotropic medications were warranted. This highlights that it is important for the psychiatrist to educate the staff and our medical colleagues about the psychiatric impact of medical conditions on patients with dementia.

If a complete work-up has been done and is negative, or if all medical conditions have been optimized, yet the yelling persists, a close review of the circumstances of the screaming may help to identify precipitants in the environment. For example, one patient who comes to mind screamed whenever there was too much stimulation in the immediate vicinity. Removing him to a more peaceful area of the unit would calm his behavior. Screaming that occurs during personal care can be extremely challenging for the personal care aides, but can sometimes be addressed by varying the personnel (at times for idiosyncratic reasons, the patient may have a predilection for a certain individual or type of individual). Allowing for creative scheduling of staff duties is essential in caring for such individuals since changing the timing of personal care can often resolve the agitation. The psychiatrist can play a vital and unique role in educating the administration and staff of a facility to prompt creative responses to agitation.

Discomfort of any kind can certainly cause screaming and attempts should be made to identify any and all sources of pain. Such situations as constipation, mild arthritic discomfort, dental pain, or evolving decubiti may be occult sources of discomfort. Even such regular occurrences as normal gas pains or mild cramping, which resolve spontaneously with time, may lead to outbursts.

Mr. Cohen is an 86-year-old resident of the nursing home. He was admitted with numerous medical problems, including hypertension, diabetes, and atrial fibrillation. All of these are currently stable. For the past two weeks he has had unremitting anguished verbal outbursts, usually with the words "help me," voiced repetitively. This led to a psychiatric consultation. Further investigation by the psychiatrist revealed that he has lost weight. Although usually a pleasant man, Mr. Cohen has become unusually irritable with his caregivers. His sleep also has become more disturbed. A complete medical work-up and physical examination has failed to reveal any source of his agitation.

In this scenario, the patient's screaming was the proximal event that led to a psychiatric evaluation. The psychiatrist determined that the screaming occurred in conjunction with other symptoms, which together led to the diagnosis of depression superimposed on his dementia. With treatment of his depression, Mr. Cohen returned to his previous baseline of functioning, and the screaming, being part of the syndrome of depression, subsided as well. Depression in dementia is a well-known source of agitation, and an increase in the levels of distressed outbursts should be considered a marker for such a possible diagnosis.

In choosing an appropriate antidepressant, consideration should be given to side effect profile and dosing. Medications with anticholinergic side effects should be avoided, while the SSRI's appear to be well tolerated.

Table 1: Antidepressants Commonly Prescribed

Name	Range Per Day	Type	Comments
Fluoxetine (Prozac)	10–40 mg	SSRI	
Sertraline (Zoloft)	25–100 mg	SSRI	
Paroxetine (Paxil)	10–40 mg	SSRI	Sedation
Escitalopram (Lexapro)	5–10 mg	SSRI	
Bupropion (Wellbutrin)	75–225 mg		Anxiety
Mirtazapine (Remeron)	7.5–30 mg		Sedation
Venlafaxine (Effexor)	25–150 mg		
Nortryptiline (Aventil, Pamelor)	10–75 mg		Serum level

Mr. Brown was described by his wife as volatile and "temperamental" all his life. She stated that he always was quick to "fly off the handle" and to yell with the slightest provocation. Having suffered several strokes, he is now in a

nursing home, where the staff report that he is extremely angry, with quick rage and cursing. He will scream at people without provocation and is equally cruel to peers and the staff. The staff view him as an angry, unkind man, who targets those more vulnerable, and who has made caring difficult. His colorful language has drawn the attention of the families of the residents, and they have urged their loved ones to shun him. As a result, he has become more isolated, which has increased his frustration and outbursts. Attempts at increasing the levels of recreational therapy and soothing environments all have failed. No new medical events have occurred. He has been placed on an antidepressant, but there has been no change in his behavior, after an 8-week trial.

Often screaming or explosive verbal outbursts will persist despite the absence of underlying medical causes or treatment for depression. Environmental manipulation has failed as well. What are our choices at this point? Mood stabilizers such as valproate and lithium have been shown to be effective, particularly for explosive type outbursts, and for those patients with impulse control disorders and disinhibition. The neuroleptics, especially the newer atypicals, such as quetiapine, risperidone, and olanzapine, are reasonably safe and well tolerated. There appears to be a consensus that the use of the benzodiazepines should be avoided, since they can cause increased disinhibition.

Table 2: Other Agents Commonly Prescribed

Name	Range Per Day	Comments
Divalproex (Depakote)	125–2000 mg	Serum level, ALT (liver function test), platelets
Lithium	150–1500 mg	Serum level, Blood Urea Nitrogren (BUN), Creatinine, Thyroid Stimulating Hormones (TSH)
Risperidone (Risperdal)	0.125–1 mg	Fasting Blood Sugar (FBS)
Olanzapine (Zyprexa)	2.5–10 mg	
Quetiapine (Seroquel)	12.5–100 mg	

In summary, prior to prescribing medication, it is helpful to review the environmental status and circumstances of the patient. Providing structure and routine, ensuring pleasant familiar activities and distractions, and keeping tasks simple can help alleviate agitation. Training staff in the techniques of redirection, reassurance, and distraction can help to soothe the individual. Teaching the staff to be flexible and creative in their approaches, and convincing the administration of the need for this creativity is essential.

When prescribing medications to this population with "sensitive brains" it is important to remember some basic principles:

1) Start all medications at the lowest dosage, and raise doses slowly.
2) Monitor blood levels if applicable.
3) Use single agents for adequate trials if possible.
4) Avoid polypharmacy.
5) Avoid sedative-hypnotics and anticholinergics.

It is important to keep in mind that although a minority of nursing home residents do not suffer from dementia, they also can exhibit psychiatric syndromes and behavioral problems. There may be individuals with pre-existing psychiatric disorders such as schizophrenia and bipolar disorder, whom when symptomatic, have verbal outbursts. The syndrome of depression is extremely common in the long-term setting and may cause irritability, yelling, and a decrease in tolerance of frustration. In general, the approach described here is applicable to these cases as well.

In summary, verbal outbursts are a common feature of life in the long-term care setting. Its occurrence may reflect a myriad of causes. Our role is to attempt to identify and treat these causes appropriately. This entails ensuring that all reversible medical conditions have been assessed, that patients have received trials (sometimes empirical) of well-tolerated antidepressants, and that consideration be given to other medication choices such as atypical neuroleptics and mood stabilizers when indicated. Creative environmental approaches can be of great assistance as well.

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"THE SEXUALLY DISINHIBITED NURSING HOME RESIDENT CAN DISRUPT THE TRANQUILITY AND CIVILITY OF EVEN THE BEST-RUN LONG-TERM CARE FACILITIES."

SEXUAL DISINHIBITION AND AGGRESSION IN THE NURSING HOME SETTING

By David S. Harnett, M.D.

Mr. H. is a 74-year-old Hispanic-American. He is a widowed nursing home resident referred for inpatient geropsychiatric admission because of escalating sexually disinhibited behavior. He has made inappropriate sexual remarks toward female staff and visitors, including propositioning, and repeatedly has grabbed the private parts of female staff and visitors. Masturbating also has been observed.

His sexual disinhibition has gradually increased over the past year. When the patient's son visited and spoke sternly with him, the behavior receded for a short time. It also transiently lessened around the time the patient sustained a myocardial infarction. At the time of referral, the son said he did not realize his father's behaviors had become so sustained, though he had stopped bringing his adolescent daughter for visits in the nursing home because his father would make inappropriate remarks. He noted that historically, his father was not at all flirtatious, that his current demeanor represented a definite personality change. Several years ago, he took his father to an outpatient geriatric psychiatrist who diagnosed vascular dementia and prescribed sertraline (Zoloft) for depression, now at 100 mg per day.

Past medical history includes insulin-dependent diabetes mellitus, hypertension, atrial fibrillation and benign prostate hypertrophy. A past head CT scan revealed evidence of small subcortical strokes. His mental status examination noted a pleasant, amiable wheelchair-bound man who seemed passive and apathetic at times, and minimized the sexual behaviors. He said it was all a "misunderstanding." "I am from one country, and they [the nursing staff] are from a different country," Mr. H. said.

The Mini-Mental State Examination score was 14/30. Serum testosterone was found to be 820 ng/dl (reference range 241-827 ng/dl).

The patient's behavioral pattern was studied in the

inpatient milieu. Though the patient was reluctant to attend group activities, the staff attempted to engage him in activities appropriate to his cognitive abilities. The inappropriate sexual remarks and groping of several female staff continued, especially on evening shifts. The use of hormonal therapy, specifically medroxyprogesterone acetate (MPA) was discussed with the patient's son, an article from scientific literature was provided, and possible side effects were anticipated. The son was eager to try the medication. The patient was placed on MPA 100 mg orally per day, and returned to the nursing home with behavioral suggestions and a copy of an article describing use of hormonal therapy. The patient's behavior was noted to improve in the months after discharge.

The Consultative Approach

The sexually disinhibited nursing home resident can disrupt the tranquility and civility of even the best-run long-term care facilities. Staff, especially those who are the object of assaults, may be physically injured and emotionally traumatized. There may be angry disagreement among nursing home personnel about whether the behavior is willful or not. Staff may call in sick, withdraw from or even refuse to work with the resident or on the unit where the resident resides. The controversy may divert staff attention from the care needs of others. Other residents may be directly traumatized or indirectly affected by the sense of disquiet. Family members of these other residents may appear at the nursing home administrator's door, demanding immediate action, guarantees that their loved ones will be protected, and possibly the exclusion of the "perpetrator" from the facility.

An initial goal of the nursing home psychiatrist when working with patients experiencing sexual disinhibition is to engage a range of staff in the consultative process, encouraging them to rationally examine sexually disinhibited behavior as yet another clinical challenge that is understandable and manageable. The observations of the nursing assistants will be essential in outlining the exact description, frequency, and time of the day of the abnormal behavior. Immediate stressors ("triggers") such as personal care, over or under stimulation, change of shift, or the presence or absence of particular staff, family, or other residents, must be sought. Collaboration with the resident's family should emphasize alliance and attempt to minimize defensiveness. Families are often embarrassed to hear of such behaviors and may then assume their loved one was always a sexual deviant, even if the behavior was concealed. They might minimize the problem (e.g., "It never happens when I'm here." or "Let him have a little fun, it's harmless.") or blame another resident. Alliance with the family is often aided by a simple explanation that most sexually disinhibited behavior in the nursing home is a recognized complication of dementia and not an indictment of a resident's personality or the upstanding life they have led. Even for residents who have a history of sexual aberrance, a superimposed dementia is often relevant.

While geropsychiatric inpatient admission may be requested, early referral to the on-site psychiatric consultant and treatment in the nursing home setting is preferred, if possible. Though an inpatient psychiatric service can return a patient to the long-term care setting with new medications and behavioral recommendations, the efforts of the psychiatric consultation are more profitably spent directly with the facility caretakers who will need to develop behavioral techniques suited to their own unique milieu. In addition, the rights of nursing home residents who are capable of consensual and non-exploitative sexual relationships should be respected.

Epidemiology, Differential Diagnosis, and Treatment

The prevalence of inappropriate sexual behavior associated with dementia is unclear and varies with the clinical setting (2.9 to 15 percent).[1]

Sexual disinhibition in the nursing home setting often appears related to dementia and may occur early in the course of dementia that preferentially affects frontal function. Such behavior may also follow acute central nervous system insult. Mania, including secondary mania (e.g., secondary to corticosteriod medication), must be considered in the differential diagnosis. Hypersexuality may be caused by dopaminergic drugs.[2] Less common causes include seizure disorders (e.g., during the postictal period, after significantly improved seizure control) and Kluver-Bucy syndrome. Though dementia-related hypersexuality is largely a condition in men, erotomania associated with dementia rarely may be seen in women.[3]

The psychiatric consultant should also identify various benign manifestations of dementia that may be misconstrued as hypersexuality. Clothing removal or masturbation in public areas, forgetting to pull one's pants up after using the bathroom, or wandering into another room may be due to forgetfulness and inattention to one's surroundings.[4] Dementia-related misidentification might cause sexual overtures toward a female resident thought to be one's spouse. Social isolation and boredom can result in a need for tactile stimulation and human contact. The consequence might be crawling into bed with another for warmth or reaching out to touch the nurse. It may be coincidental which body part is contacted.

Creative and common sense behavioral intervention should then follow, including social stimulation and recreational activities. Modified clothing to discourage public undressing and avoiding triggers (e.g., female

resident thought to be the spouse) might be employed as well as skillful personal care (e.g., not reaching across the resident) and judicious use of distraction and re-direction.

The use of medications to treat sexual disinhibition in nursing-home residents is poorly studied and ethically controversial. Antipsychotics are commonly prescribed but often are ineffective.[5] Serotonergic antidepressants have been advocated as first-line medication,[6] though the mechanism of action is unclear. Paraphilias in younger patients have been hypothesized to represent obsessive-compulsive spectrum disorder, hence the rationale for the efficacy of selective serotonin reuptake inhibitors (SSRIs). Alternatively, a direct antilibidinal effect may be relevant. Case reports have found paroxetine (Paxil)[7] and clomipramine (Anafranil)[8] helpful. However, anticholinergic effect and orthostatic hypotension will likely limit the use of clomipramine in patients with dementia.

Case reports support the use of hormonal therapies in refractory cases, including the antiandrogens medroxyprogesterone acetate (MPA)[5,9-12] and cyproterone (CPA), estrogens, and the gonadotropin-releasing hormone (GnRH) analogue leuprolide acetate. Clinical benefit from MPA is usually associated with a drop in testosterone levels. Dosages ranges have included 100 mg to 200 mg intramuscular (IM) every two weeks,[9] 200 mg to 400 mg IM every two weeks,[10] 300 mg IM weekly,[11] 200 mg to 500 mg IM weekly[6] and 100 mg by mouth daily.[12] Notable benefit is usually described, significant side effects have not been reported, and improvement may persist one year after the MPA is stopped.[11] CPA is not approved in the United States.[13]

The Institute of Living in Connecticut, which has a specific program for sexually dangerous dementia patients, has found estrogen (0.625 mg pill or transdermal patch 0.05 to 0.10 mg) to be helpful.[6] Estrogen (diethylstilbestrol one mg twice a day) lessened sexualized aggression in an elderly man with prostate cancer.[14]

Conclusion

While the nursing home psychiatrist should help the staff understand the manifestations of dementia that can be misconstrued as hypersexuality, it is equally important that significant sexual disinhibition and aggression, though uncommon, be recognized and promptly addressed.

Kathleen Fabiano and Terri Niland assisted in the preparation of this article.

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WANDERING BEHAVIOR

STAYING SAFE—A PRACTICAL GUIDE

By Douglas A. Kalunian, M.D.

Psychiatric consultations are often requested when patients with dementia develop wandering, pacing, restlessness, or other abnormal motor behaviors. These symptoms have not been as well studied as the cognitive deficits of dementia. Treatment strategies largely consist of behavioral management techniques, with psychotropic medications often having little to no therapeutic benefit.[1,2,3] Wandering, in particular, leads to significant emotional distress for caregivers, with both financial and safety consequences. As a result, this symptom has received increased attention in the research literature over the past three to five years.

Wandering, in the form of elopement from a safe home or institutional environment, is a risky and potentially life-threatening behavioral symptom of dementia. Wanderers often leave "on foot," but might also find other means of transportation. Depending on the level of their cognitive status, they might become lost and disoriented, unable to ask for assistance or to find their way back home. They may be harmed by inclement weather or vehicular traffic. They may miss crucial prescribed medications, fall on treacherous terrain, or be exposed to other dangerous features of the environment. The frightening aspect of this for families and caregivers is that once wandering starts, it often continues.

IT IS UNCLEAR WHAT INITIALLY PROMPTS WANDERING. THE CAUSE IS OFTEN MULTI-FACTORIAL, INCLUDING COMPONENTS OF ANXIETY, AGITATION, RESTLESSNESS, AND DISORIENTATION.

What Causes Wandering?

It is unclear what initially prompts wandering. The cause is often multi-factorial, including components of anxiety, agitation, restlessness, and disorientation. Other causes might include depression or psychosis. Medical illnesses (e.g., infection, dehydration, or metabolic disturbances), pain or discomfort, medication side effects (e.g., akathisia secondary to neuroleptics or anticholinergic side effects of medications), and Sundowning Syndrome all can be associated with wandering. Disorientation, with the person's inability to recognize familiar people, their home environment, or familiar objects, might lead to wandering. In addition, regression (e.g., believing that they still work or have children to

care for) can also prompt wandering, with the patient asserting that they have some personal or work-related deadline to meet. Most often, they simply want to "go home."[4,5]

Early Placement and Treatment in Long-Term Care Facilities

Wandering often plays a key role in a family's decision to place a loved one in some form of institutionalized setting to ensure "safety." The placement is usually considered "premature," since the patient would otherwise not require increased supervised or skilled care. Once placed, the tendency to wander usually persists and may increase during the initial transition. Medications are often prescribed in order to treat the associated anxiety.

However, medications may have a minimal direct effect on the patient's tendency to wander and increase the risk of falls as a result of sedation, unsteady gait, or orthostatic hypotension. Provisions of the OBRA regulations regarding the use of antipsychotic medication prohibit their use for wandering when it is the sole indication. Yet, antipsychotics can be used to treat wandering that is part of a broader behavioral syndrome with other psychiatric symptoms for which these medications would be indicated.

In a retrospective study of 2,487 physically frail older residents (including 1,836 patients with dementia) in more than 100 long-term care facilities, Bartels, et al. found that 43.5 percent of the patients with dementia had some form of agitation (without depression). Agitation was defined in the study as: wandering, pacing, restlessness, inappropriate disrobing, or verbal outbursts.[1] More than two-fifths of the patients with dementia plus agitation-alone received no psychotropic medications. However, this group also had the "highest use of physical restraints among all subgroups and suggested the need for other, more appropriate and effective psychiatric treatment."

In a case-review article on options for the treatment of behavioral disturbances in dementia, Lantz noted that no one type of psychiatric medication is more effective than others for the treatment of behavioral disturbances in dementia. However, she suggested that medication treatment should be considered when symptoms cause distress or pose a danger. Medications should be targeted at the underlying psychiatric symptoms considered to be at the root of the behavioral symptom (e.g., anxiety, depression, psychosis).[1,7]

Behavioral and Environmental Tips for Wandering

The Alzheimer's Association offers tips for both clinicians and families in treating or reducing the risk of wandering behavior in patients with dementia. The clinical literature also offers strategies for clinicians and institutions.[4,5,6]

Preventing Wandering

- Install warning bells or wander-prevention monitoring devices above doors and windows that signal when a door or window is opened.
- Locks on doors should be used with caution, given the risk of fires or other emergency situations. Note that some wander-prevention devices can automatically lock doors when a person wearing the special bracelet approaches. Slide bolts at the top or bottom of doors can be used. A simple change in a door latch might be all that is needed.
- Loosely cover doorknobs so that turning becomes more difficult.
- Cover doors with curtains or removable screens.
- Place a pressure-sensitive mat at the door or at the person's bedside that sounds an alarm when activated.
- Camouflage doors by painting them the same color as the walls.
- Consider bean bag chairs, recliners or geri-chairs for sitting, as people often require assistance in rising from them.
- Consider one-on-one, round-the-clock supervision.
- Limit the availability of alternate modes of elopement. Hide car keys and bus or metro tokens.
- Place hedges or a fence around the yard or patio, placing locks or other mechanisms on the gates to make elopement more difficult.
- Use safety gates to limit access to stairs or to the outside.[4,5,6]

Making The Residential Environment More Recognizable

- Reorient, comfort, and reassure against any confusion or disorientation, especially if the patient has recently moved to a new facility.
- Place night lights throughout the facility.
- Develop a safe environment (e.g., enclosed patio) for wandering (inside or outdoors) while still being observable by others.[4,5,6]

Discouraging the Desire to Leave

- Place a dark-colored mat in front of the door. It may be perceived as a hole and crossing it is usually avoided.
- Offer reassurance when the person feels lost, abandoned, or disoriented.
- Encourage movement and exercise to reduce anxiety, agitation, and restlessness.
- Encourage daily productive activity (e.g., folding laundry or preparing dinner).
- If wandering occurs at a consistent daily time, try to identify its cause and distract the individual with another activity during that time.
- Keep pocketbooks, wallets, and glasses out of immediate reach so that the person will ask for these items before attempting to leave the facility.

- Use signage to shift the wanderer's focus of interest or attention (e.g., "Area Under Construction"). [4,5,6]

Setting Up a Safety Network for Persistent Wandering

- Inform neighbors, police departments, and so forth of the person's condition and potential for wandering. Exchange telephone numbers. Ask that they contact you immediately if they see the person walking outside unattended.
- Design the person's wardrobe to include bright colored clothing or sew reflectors (e.g., bicycle reflectors) onto the clothing to enhance safety if wandering occurs at night.
- Enroll in the Alzheimer's Association Safe Return Program, a nationwide identification system designed to assist in the safe return of people who become lost while wandering.
- Keep a list of emergency phone numbers of the local police and fire departments, hospital, and poison control as well as Safe Return help lines.
- Keep a recent, close-up photo of the patient available to give to police or other agencies.
- Keep "scented" clothing on hand to give to police should the person become lost. Replace monthly to retain scent.
- Place on the potential wanderer: (a) some form of identification (e.g., ID bracelet) and (b) a mechanical device that beeps or makes a sound when you clap or whistle.
- Survey the neighborhood. Identify potentially dangerous areas (e.g., bodies of water, open stairwells, tunnels, dense foliage, bus stops, high balconies, and roads with heavy traffic). Check these places first, if the person wanders.
- Know whether the person is right-handed or left-handed. When wandering occurs, the person generally follows the direction of the dominant hand. [4,5,6]

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The Clinical View Two, Volume 2, Issue 2

On the answer form located on the next page, please circle the letter that corresponds to the single most appropriate answer for each of the following questions.

The deadline to receive credit is one calendar year from the date of publication. A CME Certificate will be sent to you, should you earn a passing grade of at least 70 percent.

1. When dealing with a sexually disinhibited patient, a nursing home psychiatrist must:
   A. Isolate the patient from other residents
   B. Prescribe a neuroleptic
   C. Engage a range of staff in the consultative process
   D. Recognize the behavior will eventually subside without intervention

2. A factor not commonly associated with wandering in nursing home residents is:
   A. A need to escape
   B. A medical illness
   C. Psychosis
   D. Sleep apnea

3. According to research estimates, the percentage of nursing home residents who are persistent screamers reaches:
   A. 15 percent
   B. 28 percent
   C. 33 percent
   D. 35 percent

4. Sexual disinhibition in nursing homes often is related to:
   A. Frustration
   B. Agitation
   C. Depression
   D. Dementia

5. The category of drug that might be appropriate to use to treat wandering when it is part of a broader behavioral syndrome is:
   A. SSRIs
   B. Beta blockers
   C. Antipsychotics
   D. Sedative-hypnotics

6. When treating depression in dementia, the type of medications to avoid is:
   A. Medications with anti-cholinergic side effects
   B. SSRIs
   C. Tricyclic antidepressants
   D. Dual-action antidepressants

7. The prevalence of inappropriate sexual behavior associated with dementia in nursing home patients is:
   A. 1 to 5 percent
   B. 2.9 to 15 percent
   C. 5.7 to 12.3 percent
   D. 3 to 20 percent

8. One intervention to discourage a patient from leaving a nursing home might be to:
   A. Camouflage doors by painting them the same colors as the walls
   B. Encourage daily productive activity
   C. Place night lights throughout the facility
   D. Install safety gates to limit access to the outside

9. In establishing a safety network to protect a patient who is a persistent wanderer, caregivers should:
   A. Use signage to shift the wanderer's focus
   B. Develop a safe environment
   C. Loosely cover doorknobs so that turning becomes more difficult
   D. Survey the neighborhood and identify potentially dangerous areas

10. A wanderer who is placed in a nursing home for the first time will likely:
   A. Increase elopement
   B. Stop wandering
   C. Continue to wander
   D. Encourage other wanderers

Personal Information

I certify that I have completed this educational activity and test.
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Activity Evaluation

You must complete this evaluation to ensure processing of your self-assessment test.

Please circle your answer.

Have the following educational objectives of this activity been met?

Discuss the multi-factorial components that contribute to wandering.	Yes	No
Compare treatment options for wandering.	Yes	No
Describe a variety of behavioral and environmental strategies to prevent wandering.	Yes	No
Discuss the role of staff and family in developing goals to work with sexually disinhibited residents.	Yes	No
Describe possible causes of sexual disinhibition.	Yes	No
Describe behavioral interventions that may decrease sexual disinhibition.	Yes	No
Explain the advantages and disadvantages of pharmacologic interventions for sexual disinhibition.	Yes	No
List factors that cause screaming.	Yes	No
Discuss the initial assessment for screaming.	Yes	No
Describe appropriate therapeutic options to alleviate screaming.	Yes	No

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Very Relevant				Irrelevant
5	4	3	2	1

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5	4	3	2	1

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5	4	3	2	1

Overall evaluation of activity:

Excellent				Poor
5	4	3	2	1

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