

Evaluation and Management of Behavioral and Psychological Symptoms of Dementia

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1

Disclosure

I have no financial interests or relationships to disclose.



2

Objectives



Be able to describe factors precipitating behavioral disturbances



Rule out medical, environmental, and caregiving causes of behavioral problems



Use environmental and non-pharmacologic management strategies to minimize/treat behavioral disturbances



Review medication management options to use when necessary



3

ARS Question #1

A 76-Year-Old With Moderate Alzheimer's Dementia Presents With His Wife to Clinic. She Is Visibly Exhausted and Notes That for the Past 2 Months He Has Had Increasing Agitation in the Evenings, Follows Her Everywhere, and Repeats the Same Questions. She Asks, "Is This Normal, or Is His Dementia Progressing Faster Than Everyone Else's?"

What Accurately Reflects the Likelihood of a Patient Experiencing BPSD Over the Course of Their Disease?

- A. 75% of patients develop significant behaviors, typically restricted to the terminal stages of the disease
- B. Nearly 50% of patients experience behaviors, almost exclusively in vascular and frontotemporal dementias, no Alzheimer's
- C. Up to 90% of patients will experience at least one behavioral symptom during their disease
- D. BPSD occurs in 40% of patients and is usually a direct indicator of an underlying acute medical illness



4

Behavioral and Psychological Symptoms of Dementia

(BPSD)

- 80%–90% of patients with dementia develop at least one distressing symptom over the course of their illness
- Prevalence increases with disease severity
- Often precipitate early nursing home placement
- Cause increased caregiver burden and decreased QOL for patients
- Disturbances are potentially manageable

Common Behavioral Disturbances

Agitation/ Aggression	Sundowning	Delusions	Hallucinations
Paranoia	Wandering	Hoarding	Depression/ Anxiety
Apathy	Disinhibition/ Hypersexual behaviors	Sleep disturbances	Resistance to care

Screening for Behaviors

- Should be done at each regular follow-up visits with CG/Family
 - Does the patient have any behaviors that worry you?
 - Do you/the patient have hallucinations, see things, or hear voices that aren't there?
 - How do you/the patient sleep at night?
 - Regularly inquire about aggression, delusions, hallucinations, paranoia, wandering, depression, apathy, and disinhibition

Assessment Scales to Quantify BPSD

- More than 83 different scales exist

BPSD Scale	Care Location	Time to Administer
CMAI: Cohen Mansfield Agitation Inventory	Any	10-15 minutes
NPI: Neuropsychiatric Inventory	Office	7-10 minutes
Dementia Observation System	Care Facility	5 min/day

Assessment of Behavioral Symptoms

- Get comprehensive assessment from patient and caregiver/family
- Get a clear description of the behavior
 - Temporal onset, course, associated circumstances, and its relationship to key environmental factors such as caregiver status and recent stressors
- Once you have a good understanding of what the behavioral symptom the patient is experiencing is, then you want to look into potential causes in the context of the patient's family and personal, social, and medical history



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9

Take Home Point

Conceptualize
challenging behaviors
as *symptoms* instead of **problems**.



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10

Proactive Treatment Approach

- Address physical health
- Assess the physical environment
- Assess social environment
- Help the helper



11

Assessment of Behavioral Symptoms

- Did the symptoms start suddenly?
- Do they notice any triggers or times of the day they tend to occur?
- Is the behavior a symptom of a medical condition, or discomfort due to a medical condition (e.g., UTI), or acute infection?
- Is the patient in pain?
- Is the patient constipated?
- How is their oral intake? Are they dehydrated?
- What medication is the patient taking? Any new meds?
- Has the patient experienced a change in environment?
- Is there stress in the patient-caregiver relationship?



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12

Physical Health

- Fatigue due to poor sleep
- Medical condition
- Clinical depression
- Sleep disturbances
- Vision loss or lack of proper eyeglasses
- Hearing loss or lack of working hearing aid (check batteries)
- Ill fitting dentures
- Constipation
- Dehydration
- Need to urinate
- Hunger
- Pain
- Delirium
- Medication Side Effect
 - Remove offending meds, particularly anticholinergic



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13

Physical Environment

- Physical space
- Daily routine
- Sensory stimulation
- Time Changes
- Keep the environment comfortable, calm, and homelike with use of familiar possessions
- Provide regular daily activities and structure; refer patient to adult day care programs, if needed



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14

Social Environment

- Moving to a new residence or nursing facility
- Changes in a familiar environment or caregiver arrangements
- Changes in family roles/responsibilities
- Changes in quality of friendships



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15

Help the Helper

- Educate and set expectations with caregivers
- Ensure that caregiver has adequate respite and resources
- Provide access to experienced professional and community resources
- Refer to local Alzheimer's Association
- Consult with geriatric professionals



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16

Help the Helper

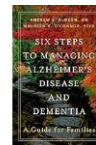
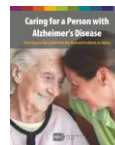
- Does the patient know who you are? Your intentions?
- How do you communicate with the patient?
 - What are you saying?
 - What is your tone saying?
 - What is your body language saying?
- Are you acting like the boss of them?
 - “Calm down.”
 - “You need to take your pills.”
 - “We told you three times already to sit down.”



17

Caregiver Support

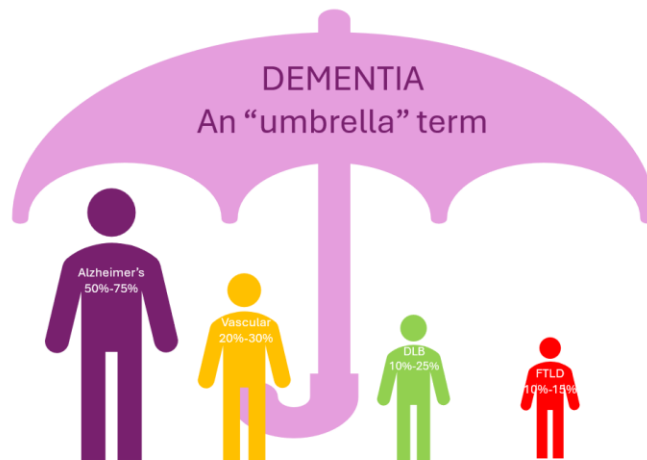
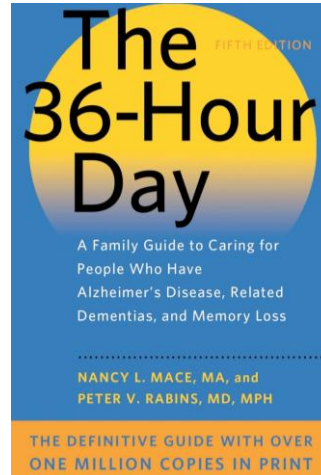
- **Attorney** for will, conservatorship, estate planning
- **Community:** neighbors & friends, aging & mental health networks, adult day care, respite care, home-health agency
- **Organizations:** Alzheimer's Association, Area Agencies on Aging, Councils on Aging
- **Services:** Meals-on-Wheels, senior citizen centers
- **Level of Care:** ILF, group home, ALF, MCU, LTC, VA Aid and attendance, LTC insurance
- **Caregiver support and education can also delay placement by 6 months!**



18

Catastrophic Reaction

- Defined as an acute behavioral, physical, or verbal reaction to environmental stressors that results from inability to make routine adjustments in daily life



Non-Pharmacological Management

- Sensory-Oriented Approaches
- Emotion-Oriented Approaches
- Behavior Management Techniques
- Practical Techniques



21

ARS Question #2

You Are Treating an 82-Year-Old Female With AD Who Appears to Have Aggressive Behavior Only Emerging in Times of Confusion.

Which of the Following Non-Pharmacologic Interventions Has the Best Level of Evidence Supporting Its Use?

- A. Simulated Presence Therapy (SPT)
- B. Music Therapy
- C. Validation Therapy
- D. Transcutaneous Electrical Nerve Stimulation (TENS)
- E. Pet Therapy



22

Sensory-Oriented Approaches

- Acupuncture
- *Aromatherapy
- *Exercise training combined with CG education
- Light Therapy
- *Massage and Touch
- *Music Therapy
- *Pet Therapy
- *Snoezelen Multisensory Stimulation Therapy
- Transcutaneous Electrical Nerve Stimulation (TENS)
- *Transcranial Magnetic Stimulation (TMS)

*=some evidence of benefit



Opie J, Rosewarne R, O'Connor DW. The efficacy of psychosocial approaches to behavioral disorders in dementia: a systematic literature review. *Aust N Z J Psychiatry*. 1999 Dec;33(6):789-99. doi: 10.1046/j.1440-1614.1999.00652.x. PMID: 10619204

Yin Z, Li Y, Bao Q, Zhang X, Xia M, Zhong W, Wu K, Yao J, Chen Z, Sun M, Zhao L, Liang F. Comparative efficacy of multiple non-pharmacological interventions for behavioral and psychological symptoms of dementia: A network meta-analysis of randomized controlled trials. *Int J Ment Health Nurs*. 2024 Jun;33(3):487-504. doi: 10.1111/inm.13254. Epub 2023 Nov 27. PMID: 38012101.

23

Henry



24

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Emotion-Oriented Approaches

- Reminiscence Therapy
- Simulated Presence Therapy (SPT)
- Validation Therapy

*=evidence of benefit



Zetteler J. Effectiveness of simulated presence therapy for individuals with dementia: a systematic review and meta-analysis. *Aging Ment Health*. 2008 Nov;12(6):779-85. doi: 10.1080/13607860802380631. PMID: 19023729.

25

Behavior Management Techniques

- *Behavior Management Techniques:
 - Functional analysis of specific behaviors
 - Behavior therapy and habit training
 - Cognitive Behavioral Therapy (CBT)
 - Progressive muscle relaxation
 - Person-centered communication skills training for caregivers
 - Various types of individualized behavioral reinforcement strategies

*=evidence of benefit



Teri L, Logsdon RG, McCurry SM. Nonpharmacologic treatment of behavioral disturbance in dementia. *Med Clin North Am*. 2002 May;86(3):641-56, viii. doi: 10.1016/s0025-7125(02)00006-8. PMID: 12168563.

26

So, What Works?

EVIDENCE IS LACKING BUT THE LITERATURE SEEMS TO SUGGEST THAT SENSORY-ORIENTED APPROACHES SHOW GREATER PROMISE THAN EMOTION-ORIENTED APPROACHES.

SOME EVIDENCE TO SUGGEST THAT BEHAVIOR MANAGEMENT TECHNIQUES ARE EFFECTIVE STRATEGIES TO REDUCE BEHAVIORAL SYMPTOMS OF DEMENTIA.

Putting It All Together



Given the lack of certainty of overall benefit from these interventions, implemented programs should strive to minimize associated harms



Less risky than medications



Not all forms of non-pharmacologic treatments for dementia may be appropriate for all patients

Practical Techniques

Agitation	Redirection, redirection, structure routines, calm responses
Paranoia	Remove mirrors
Sundowning	Exposure to light
Wandering	Door alarms
Hypersexual	Move room/adaptive clothing
Resistance to Care	36 Hour Day



29

ARS Question #3

A 67-Year-Old Patient With DLB Is Having Social Withdrawal, Anxiety, Feelings of Worthlessness and Increasing Irritability for the Past 2 Months. They Have a Score of 10 on the Geriatric Depression Scale (GDS).

What Is the First-Line Medication for These Symptoms?

- A. Paroxetine 20 mg daily
- B. Bupropion 150 mg daily
- C. Sertraline 25 mg daily
- D. Sertraline 50 mg daily
- E. Amitriptyline 50 mg nightly

30

When Medications Are Needed

- Primary goal of treatment
 - Enhance quality of life
 - Maximize functional performance by improving or stabilizing cognition, mood, and behavior



31

Medications

- Use CAUTION with pharmacologic treatment
- **Evidence demonstrates** that **pharmacological** interventions are ineffective in managing behavioral problems in patients with dementia
- Potential side effects are frequent and often hazardous

Start low and go slow!



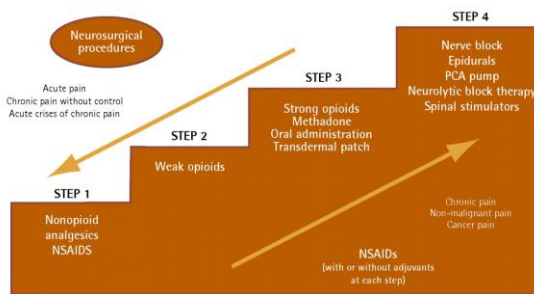
Teri L, Logsdon RG, McCurry SM. Nonpharmacologic treatment of behavioral disturbance in dementia. Med Clin North Am. 2002 May;86(3):641-56, viii. doi: 10.1016/s0025-7125(02)00006-8. PMID: 12168563
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32

Pain Management

- Prescribe a trial of scheduled analgesics.
- Use a stepped-care approach to analgesic prescribing.
- Start low, go slowly, but use enough.
- Monitor the patient carefully to balance risks and benefits of pain treatment versus persistent pain.

Figure 2. New adaptation of the analgesic ladder



NSAID=nonsteroidal anti-inflammatory drug, PCA=patient-controlled analgesia.

Agitation/BPSD

Cholinesterase Inhibitors

- Evidence is not robust often well tolerated and may have additional benefit for cognition and function
 - 2015 systematic review and meta-analysis found small but statistically significant efficacy
 - Compared to placebo they may reduce the rate of emergence of behavioral disturbances and psychosis (SOE=B).
 - Once behavioral and psychological symptoms are present, cholinesterase inhibitors have not shown any reduction in symptoms
- Dementia with Lewy bodies (DLB) may have a more beneficial response to cholinesterase inhibitors than patients with AD
 - Especially for reduced visual hallucinations (SOE=C).

Agitation/BPSD

Limited Evidence for Antidepressants



Efficacy and tolerability of antidepressants monotherapy for behavioral and psychological symptoms of dementia: A meta-analysis of randomized controlled trials

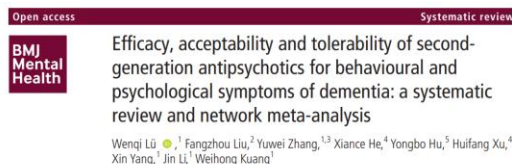
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Agitation/BPSD

Medications with Some Efficacy

- Brexpiprazole (Rexulti) demonstrated superior efficacy compared to placebo
- Aripiprazole (Abilify) has best acceptability profile



Agitation/BPSD

Anticonvulsants

- Current evidence indicates anticonvulsants are unlikely to be effective
- Gabapentin efficacy is unproven



Agitation/BPSD

What Not to Use...

- Benzodiazepines **are not** recommended for the management of neuropsychiatric symptoms of dementia
 - Use should be limited to brief stressful episodes, such as a change in residence or an anxiety-provoking medical event
 - Side effects include worsening gait, potential paradoxical agitation, and falls
- Antihistamines and other sedatives are not recommended
 - High rates of side effects, particularly for drugs with anticholinergic effects, such as diphenhydramine

Mood Disturbances

- Screen for depression
 - If lasts >2 weeks and resulting in significant distress or functional impairment, consider trial of antidepressant + behavioral interventions
 - If lasts >2 months after behavioral interventions, treatment with antidepressant is needed

Depression

- SSRI first line
 - Sertraline or Citalopram (risk of QT prolongation, max 20 mg/d)
- SNRI, bupropion can be considered (caution if anxiety)
- Mirtazapine for sleep/weight gain

Depression

- Augment with methylphenidate
 - But risk of increasing psychotic symptoms
 - Great in end-of-life depression, apathy
 - Avoid with bupropion
- ECT
 - most efficacious and rapidly effective treatment for severe major depression and has a favorable safety profile even in mild dementia (SOE=B).

Manic-Like Behavioral Syndromes

- Pressured speech, disinhibition, elevated or irritable mood, intrusiveness, hyperactivity, impulsivity, or reduced sleep
- Treat with mood-stabilizing agents, such as Depakote, carbamazepine, lamotrigine, gabapentin, lithium, pregabalin
- Divalproex sodium sustained release is commonly recommended (SOE=C)
- Divalproex sodium
 - 125 mg q 12 hour, titrate upward
 - Blood levels 50-100 shown to be effective
 - Monitor LFTS and CBC, at start and q6 months

Manic-Like Behavioral Syndromes

- Carbamazepine
 - Starting at 100 mg q12h
 - Monitor LFTs and CBC –q dose increase and q 3 month
- Lamotrigine
 - Approved by the FDA for treatment of mania
 - No trials have been conducted in older adults.
- Lithium
 - Good mood stabilizer, but enhanced sensitivity to adverse events in older adults
- Gabapentin and Pregabalin
 - have been used for states that include hyperactivity, restlessness, and impulsivity, but concerns remain regarding dosing, risk of falls, and excess sedation

Apathy

Common and Can Occur With or Without Comorbid Depression

- Management is challenging
- First line:
 - Cholinesterase inhibitors may have some positive effect on apathy,
 - Memantine may have benefit
- Second line (if distressing to the patient or caregiver)
 - Therapeutic trial of an antidepressant and methylphenidate
 - Methylphenidate has the potential to precipitate agitation or worsen nighttime sleep
 - Use of low doses (eg, starting with 5 mg once daily in the morning, maximum dose 10 mg twice daily, last dose no later than lunchtime) with careful monitoring during titration recommended

Delusions and Hallucinations

- Delusions=fixed false beliefs
- Hallucinations=false perceptions, sensory experiences without stimuli
- Clinical criteria for the diagnosis of Alzheimer's dementia with psychosis specifies the presence of delusions or hallucinations for at least 1 month, at least intermittently, and must cause distress for the patient
- Antipsychotics are commonly used for treating psychosis in persons with dementia
 - All antipsychotics are off-label for treatment of psychosis in dementia
 - All have black box warning-increased risk of mortality with dementia



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45

Delusions and Hallucinations

- If the patient is disturbed by them can do trial of antipsychotic, 2nd line preferred over haloperidol
 - Olanzapine or risperidone- modest efficacy/benefit in RCT
 - Quetiapine is most sedating
 - Clozapine is helpful in patients with psychosis associated with PD or Lewy body
 - Rexulti (brexpiprazole)-newly approved 2nd gen for dementia-associated agitation in AD
 - Pimavanserin-studied for Parkinson disease-related psychosis. Adverse effects include QT prolongation.



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46

Delusions and Hallucinations

- Efficacy of antipsychotics in large controlled trials has been modest
- Use of antipsychotics should take into account side effects (sedation, hypotension, and falls are common to all)
- All antipsychotics have warnings about hyperglycemia, cerebrovascular events and black box warning for increase in all-cause mortality in patients with dementia
 - Second generation antipsychotics increase mortality in placebo-controlled studies (SOE=A)
 - First generation antipsychotics increase mortality in two observational studies (SOE=B)

Antipsychotic Medications

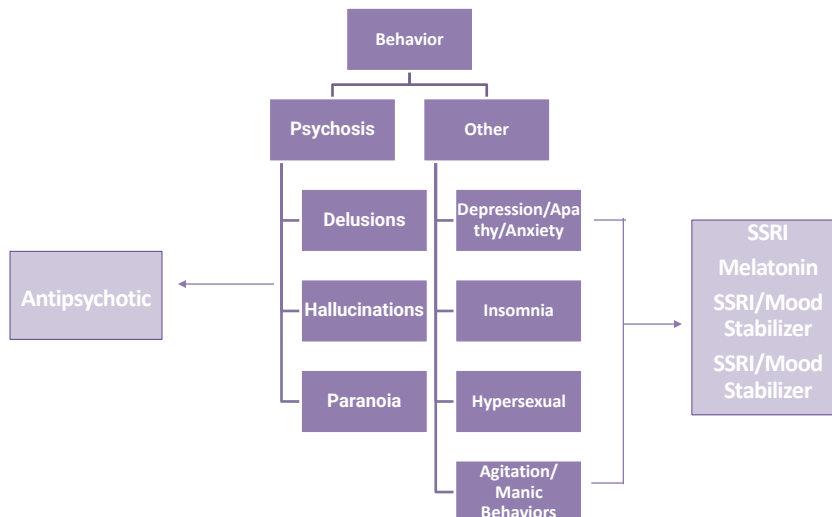
Medication	Dosage (mg/d)	Adverse events	Formulations	Comments
Aripiprazole ^{OL}	2–20	Mild sedation, mild hypotension	Tablet, rapidly dissolving tablet, IM injection, liquid concentrate	Give in AM
Asenapine ^{OL}	5–10 (tablet) 3.8–7.6 (patch)	Sedation	Sublingual tablet, transdermal skin patch	Rare reports of anaphylactic reaction
Brexpiprazole ^{OL}	0.25–4	Respiratory tract infection, akathisia, weight gain	Tablet	Pharmacologic action similar to that of aripiprazole (partial D ₂ dopamine agonist)
Clozapine ^{OL}	12.5–200	Sedation, hypotension, anticholinergic effects, agranulocytosis	Tablet, rapidly dissolving tablet, suspension	Weekly CBCs required; poorly tolerated by older adults; reserved for treatment of refractory cases
Haloperidol ^{OL}	0.5–3	Extrapyramidal symptoms, sedation	Tablet, liquid, IM injection, long-acting injection	First-generation agent
Iloperidone ^{OL}	1–12	Sedation, orthostatic hypotension	Tablet	Dosage reduction with use of CYP3A4 and CYP2D6 inhibitors
Lurasidone ^{OL}	40–80	Sedation	Tablet	Do not exceed 40 mg/d with

Antipsychotic Medications

Medication	Dosage (mg/d)	Adverse events	Formulations	Comments
Olanzapine ^{OL}	2.5–15	Sedation, falls, gait disturbance	Tablet, rapidly dissolving tablet, IM injection	Weight gain, hyperglycemia
Paliperidone ^{OL}	1.5–12	Sedation, fatigue, GI upset, extrapyramidal symptoms	Sustained-release tablet, depot IM long-acting injection	Dosage reduction in renal impairment
Perphenazine ^{OL}	2–12	Extrapyramidal symptoms, sedation	Tablet	First-generation agent
Pimavanserin ^{OL}	17–34	Peripheral edema, nausea, constipation, confusion	Tablet	No dosage adjustment required in mild-moderate renal impairment; not advised in hepatic impairment; only approved for hallucination and delusion associated with Parkinson disease psychosis.
Quetiapine ^{OL}	25–200	Sedation, hypotension	Tablet, sustained-released tablet	Ophthalmologic examination recommended every 6 months
Risperidone ^{OL}	0.5–2	Sedation, hypotension, extrapyramidal symptoms with dosages >1 mg/d	Tablet, rapidly dissolving tablet, depot IM long-acting injection, liquid concentrate	
Ziprasidone ^{OL}	40–160	Higher risk of QTc prolongation	Capsule, IM injection	Little published information on use in older adults

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My Process



Other Medication Options

Dextromethorphan-quinidine (Nuedexta)

- Approved for symptomatic treatment of pseudobulbar affect
- Limited evidence suggests that it may provide some benefit for severe agitation in patients with dementia
- When cost is not prohibitive and other management strategies have failed, a trial of dextromethorphan-quinidine may be reasonable

BEST PRACTICES IN PSYCHIATRY: RECOMMENDATIONS FROM THE CHOOSING WISELY CAMPAIGN

RECOMMENDATION	SPONSORING ORGANIZATION
Do not prescribe antipsychotic medications for behavioral and psychological symptoms of dementia in individuals with dementia without an assessment for an underlying cause of the behavior.	American Medical Directors Association
Do not use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.	American Geriatrics Society American Psychiatric Association
Source: For more information on the Choosing Wisely Campaign, see http://www.choosingwisely.org. For supporting citations and to search Choosing Wisely recommendations relevant to primary care, see http://www.aafp.org/afp/recommendations/search.htm.	

Sleep Disturbances

Improve Sleep Hygiene

- Establish a stable routine for going to bed and awakening
- Advise and educate caregivers on the natural fragmented sleep patterns associated with dementia
- Pay attention to noise, light, and temperature to optimize sleep environment
- Increase daytime activity and light exercise
- Reduce or eliminate caffeine, nicotine, alcohol
- Reduce evening fluid consumption to minimize nocturia



53

Sleep Disturbances

Sleep Hygiene

- Give activating medications (e.g., steroids) early in the day
- Control nighttime pain
- Limit daytime napping to periods of 20–30 minutes
- Use relaxation, stress management, and breathing techniques to promote natural sleep
- Provide a safe environment for the patient to stay awake if unable to sleep



54

Sleep Disturbances

Medication Management

- Moderate-certainty evidence
 - Orexin receptor antagonists ([lemborexant](#) and [suvorexant](#)) improve total sleep time and decrease time awake during the night in patients with AD
- Low-certainty evidence
 - Melatonin (effective for RBD at high doses)
 - Trazodone
 - Mirtazapine (if used for depression)
- No evidence of benefit in AD
 - Ramelteon (melatonin agonist)

McCleery et al. Pharmacotherapies for sleep disturbances in dementia. Cochrane Database Syst Rev. 2020;11(11):CD009178. Epub 2020 Nov 15.



55

Sleep Disturbances

Medication Management

- Gabapentin has sedative properties but a/e of ataxia and confusions
- Avoid Benzodiazepines and antihistamines
 - carry a high risk of falls, hip fractures, disinhibition, and cognitive disturbance when prescribed for patients with dementia
- Zolpidem (Ambien) and zaleplon (Sonata) may be helpful, but no controlled trials for sleep disturbances secondary to dementia
 - Recommended dose is <5 mg of zolpidem, short acting for short duration/intermittent administration (<3x/week)
- Consider polysomnography, when indicated

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56

Inappropriate Sexual Behavior

- Antidepressants (SSRI, trazodone, TCA-clomipramine)
 - have been used with variable success
- Dangerously hypersexual/aggressive
 - 2nd generation antipsychotic
 - Depakote
- Consider antiandrogens for men who are dangerously hypersexual or aggressive (SOE=D):
 - Medroxyprogesterone OL 5 mg/day orally; adjust dose to suppress testosterone well below normal
 - If patient responds, may treat with 100-600 mg IM depot progesterone weekly
 - Leuprolide acetate OL 5–10 mg IM monthly is an alternative

Take Home Points

- Conceptualize challenging behaviors as symptoms instead of problems.
- Rule out medical, environmental, and caregiving causes of behavioral problems .
- Use pharmacological treatments only as a last resort.