Apathy in-service

**Behaviour Management**
*A Guide to Good Practice*

*Working with people with dementia who present with apathy*

A presentation for residential aged care staff and community care staff prepared by the Dementia Collaborative Research Centres (DCRC-ABC) for the Dementia Behaviour Management Advisory Services (DBMAS)

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**Objectives**

At the end of this presentation participants will have an increased understanding of:

- How apathy presents in people with dementia
- Diagnostic criteria & potential cause of apathy in people with dementia
- Strategies & considerations to assist in the care of people with apathy in dementia

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**Apathy in dementia is...**

- an internal state of lack of interest
- state of behavioural inaction
- relative to previous functioning levels
- not attributable to intellectual impairment, emotional distress or diminished consciousness

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**What does apathy look like in dementia?**

- Decreased motivation, initiation & persistence
- Social disengagement
- Emotional indifference or absence

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**Apathy in dementia may present as:**

- Reduced persistence
- Lack of interest
- Blunted affect
- Reduced energy
- Reduced motivation
- Reduced enthusiasm
- Reduced emotion
- Lack of spontaneity
- Reduced affection

*Emotional distress is typically absent*
Apathy in dementia may be caused by a complex interaction of:
• underlying brain disease
• unmet needs
• sensory impairments
• impoverished environment
• reduced environmental cues
• boredom, isolation, loneliness
• adverse effects of medication
• possible underlying depression

Diagnosing apathy in dementia
• Eliminate reversible causes of hypoactive delirium
• Differentiate between apathy & depression
• Treat potentially underlying causes

Pathology of apathy
Dementia is associated with brain changes that can lead to apathy
+ Interaction between the individual & the environment

Differentiating apathy & depression
• Apathy is commonly misdiagnosed as depression
• Those with apathy present as compliant or passive
• Those with depression are deliberately avoidant
• Unlike depression, apathy not typically associated with insomnia, impaired attention, hopelessness, anxiety &/or sadness

Diagnostic Considerations
Using a person centred approach, gather ALL potentially important information:
▼ Could this apathy be due to pain/discomfort, physical illness/injury or other physical causes?
▼ Could symptoms be due to medication side effects?
If YES, respond & treat accordingly FIRST

If NO, consider management options
▼ Develop & trial individually tailored psychosocial/environmental strategies & interventions
▼ Only where necessary, use individually targeted medication
▼ Review!
Measuring apathy in dementia

Instruments to assist:
- Apathy Evaluation Scale (AES)
- Apathy Inventory (IA)
- Neuropsychiatric Inventory (NPI) & NPI-Clinician (NPI-C)

Prevalence of apathy in dementia

- Apathy occurs in up to 70% of persons with AD
- Highest prevalence in PSP, FTD & severe AD
- Apathy tends to
  - present early in dementia
  - increase with dementia severity
  - persist

Effects of apathy

- Carer/ family burden & distress
- Disability & frustration
- Quality of life
- Physical health
- Independence in ADLs
- Care hours & attention in RACF
- premature placement in RACF

Before you move on, have you:

- ensured that the person & all those in their environment are not at risk?
- provided a full person-centred assessment of the behaviours presented?
- excluded &/or treated any potentially reversible factors

Your approach

- Calm
- Gentle
- Take time
- Thoughtful
- Ensure comfort
- Work with the feeling
- Look behind the behaviour

Caring approaches & interventions

First line approach:
- Psychosocial &/or environmental
- Tailored/ individualised therapeutic interventions
- Music
- Reminiscence-based interventions
- Pet therapy
- Multi-sensory stimulation
Principles of psychosocial responses

- Encourage engagement
- Reassurance
- Clear communication
- Targeted
- Individualised
- Acceptance
- Simplify environment
- Empathy
- Your approach

Caring approaches & interventions

2nd line approach - biological

- Use when unresponsive to psychosocial interventions or residual symptoms are present
- ChEIs provide best evidence
- NO evidence for antidepressants or anticonvulsants

2nd line approach – biological cont.

Where pharma is prescribed:
- Use with caution – short term only
- Use in combination with psychosocial interventions
- Atypical antipsychotics:
  - NOT recommended due to potentially serious side effects
  - be aware of risks with long term use
- Monitor closely & REVIEW!

A clinical scenario - Mrs P

Mrs P - presentation

- Has been an efficient homemaker & loving mother of 4
- After death of husband, it became evident he had been significantly compensating for her functional losses
- Was supported at home by children & community services for 1 year following husband’s death
- Presented physically well on RACF admission
- Staff report – “lovely lady, no trouble”

Mrs P - presentation cont.

- Responded positively to family visits & outings
- Family visit regularly - always find her sitting alone & unoccupied in her room
- They complain to staff that Mum "does nothing" & "speaks to no one" between their visits
- Staff avoid family because they are unsure how to deal with them
Mrs P
What are some of the potentially contributing factors for Mrs P’s apathy?

Potentially contributing factors cont.
- Unfamiliar/ altered/ deprived physical environment
- Reduced ability to initiate activities for herself
- Activities offered not of interest/ unfamiliar/ too difficult
- Impaired hearing &/or eyesight

Mrs P - potentially contributing factors
- Unreported pain/ discomfort/ acute illness/ infection
- Medication interactions, dosage, adverse effects, recently prescribed
- Lack of stimulation
- Look at premorbid personality – past participation in group activities

Mrs P
With the potentially contributing factors in mind, what aspects of Mrs P’s situation could be important in your assessment?

Mrs P - assessing the situation
- Encourage Mrs P to express her concerns as far as she is able
- Observe response to items brought in by family
- Ask staff to identify activities she enjoys
- Consult life history, behavioural & clinical charts
- Consult family members - identify past activities Mrs P enjoyed

Mrs P - some outcomes
Be alert to the potential impact of the loss of former life roles when addressing apathy

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Apathy in dementia - conclusions
• Seek to understand what the apathy means for the person
• Treat underlying depressive symptoms where indicated
• Individualised, psychosocial interventions recommended as 1st line approach
• Individually tailored, therapeutic activities provide best evidence

‘Success’
• Typically not about eliminating BPSD
• Has BPSD?
• Has person with dementia’s distress?
• Has carers’ understanding of potential causes?
• Has carers’ skills/coping?
• Do carers feel supported?
• Be realistic about goals/outcomes
• BPSD are SYMPTOMS of dementia!

Resources
Alzheimer’s Australia Help Sheets
Translating what we know about pain recognition & management in people with dementia
Dementia Outcomes Measurement Suite

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Reflection & review
How can you use this information to make a difference in the lives of people with dementia who present with apathy in dementia?
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